Voices of Women

I look at every day as being a learning experience; I'm going to learn something new every day. And that's how I look at life today.

I just need other community members to be aware and understand, and believe that they can come back to some kind of normal.

Be thankful for what you have "I have to thank the Creator for the message that seemed to say, "Don't cry I'm alive".

University of Alberta

Resilience in First Nations Women

By

Lyla Goin

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Nursing

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Dedication

I dedicate this thesis to the women who so freely shared their stories with me in order to benefit their communities. I admire your courage and strength to move on and grow in spite of your loss. I give you my heartfelt thank you for the lessons that I have learned through working with you.

Abstract

The purpose of this study was to explore resilience in First Nations women following the loss of a loved one by suicide. A participatory action research design was used to conduct the qualitative, descriptive study. Ten women participated in two in-depth interviews that were analyzed to identify emerging themes. In spite of experiencing a very difficult loss the women were able to keep going and to foresee a better future. After a very difficult adjustment period, the women reached a turning point and were able to accept their loss and move on with their life. Spiritual belief, support of family and friends and previous family teaching were the key supportive factors identified by the women in their healing journey. The lessons learned from the suicide helped the women to cope with other adversities and motivated them to give back to their community.

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Introduction

Suicide is a tragically common experience in Aboriginal[1] communities. Despite the serious and pervasive nature of the problem there has been limited research to explore how families cope following the suicide of a loved one. Grief due to suicide is an intensely difficult and distressing experience. Following a suicide death some bereaved relatives suffer from depression and guilt and they may use self destructive behaviors such as the abuse of drugs, alcohol or prescription drugs, or even their own suicide to cope.

Studies have been done with populations of women who exhibit exceptional strength in the face of adversity (Humphreys, 2003; Todd & Worell, 2000; Valentine & Feinauer, 1993), and it is evident that many Aboriginal women also demonstrate this strength in coping and assisting the remaining family members to deal with a suicide. To date, however, no study has been conducted that explicitly focuses on the resilience of Aboriginal women following the loss of a loved one to suicide. The purpose of this study was to explore the concept of resilience in Aboriginal women in the face of this adversity. A better understanding of how Aboriginal women cope and survive the loss of a loved one to suicide may provide information that can be used to develop interventions that will assist other women to develop resilience.

---

[1] The term Aboriginal as used in this study includes individuals who identify themselves as Métis, First Nation, or Inuit regardless of treaty status (McLeod, 1997)
The term First Nation refers to those persons who are registered as Indians under the terms of the Indian Act and whose names appear in the Indian Register maintained by the Department of Indian Affairs and Northern Development. (Health Canada, 1996). This term replaces the term Indian.

Literature Review

The Aboriginal population generally, and women and children specifically, are under-represented in Canadian health research (Young, 2003). Research that focuses on Aboriginal health is needed to document health disparities and to support the development of health programs (Brown & Fiske, 2001). Ladd-Yelk (2001) found that research on family resiliency factors of Native American families is almost nonexistent. Two major Aboriginal reports have recommended that research be conducted in the area of Aboriginal Health (National Aboriginal Health Organization, 2002; Stout, Kipling & Stout, 2001). The National Aboriginal Health Organization (2002) has recommended that research be conducted to explore mental health including cultural and spiritual aspects of health and effective approaches to promoting health. The Aboriginal Women's Health Research Synthesis Project (Stout, Kipling & Stout) recommended that work be undertaken in the area of Aboriginal women's resiliency. Research on the problems that Aboriginal populations face has important implications for health service delivery and for mental health promotion (Kirmayer, Brass & Tait, 2000).

A review of the literature related to Aboriginal views of health, resilience of women, mental health in Aboriginal communities, and grief following suicide was conducted using the following databases: CINAHL, Academic Search Premier, MEDLINE, Social Science Abstracts, and Blackwell Synergy. Key search terms to guide the review included: Aboriginal health beliefs, resilience, Aboriginal mental health, suicide, bereavement and grief. The focus of the current study was First Nations women in Alberta however there is very little published literature specific to First

Nations people. Therefore research related to Aboriginal, Indigenous and Native American people was reviewed.

A substantial body of literature was found that focused on resilience and grief following suicide, however, no studies were found that focused on resilience in Aboriginal women following the death by suicide of a loved one. This review focused on: Aboriginal views of health; resilience of women in adverse situations; enhancing factors for resilience; mental health issues in Aboriginal communities; and the experience of bereavement following suicide of a family member. The review of articles related to suicide was limited to the grief experience of family members bereaved by suicide. These family members are referred to as survivors.

Aboriginal Views of Health

Western medicine tends to focus on the human organism and its symptoms of dysfunction. Scientific thought distinguishes the body from the person and establishes a dichotomy between the body and the spirit, separating the individual from the human and physical environment (Royal Commission on Aboriginal People, 1993). This is in contrast to Aboriginal views of health, which consider health and wellness to be a state of balance between mind, body, spirit, and emotions. An Aboriginal view of health considers the body, emotions, and spirit to be interconnected and inseparable (Alberta Health and Wellness, 2004; Aboriginal Healing Foundation, 2006; Cardinal, Schopflocher, Svenson, Morrison, & Lang, 2004; Smylie, Kaplan-Myrth, Tait, Martin, Chartrand, & Hogg, 2003; MacKinnon, 2005). Furthermore, the individual cannot be separated from the family, community, and all life. Aboriginal concepts of health and

healing view all elements of life and living as interdependent, and, by extension, believe that well-being flows from balance and harmony among the elements of personal and collective life. Imbalance can threaten the conditions that enable an individual to reach his or her full potential as a human being. For this reason, health and social problems cannot be isolated from one another (Royal Commission on Aboriginal People, 1996). Health inequities point to the underlying causes of the disparities which are largely outside of the typical domain of health (Adelson, 2005). Resources for achieving health must come from an understanding of the strength of the family, community, culture and spiritual beliefs, and of continuity with the environment. An awareness of a First Nations world-view and knowledge of local cultural resources will enhance the facilitation of well-being in First Nations people (Wyrostok & Paulson, 2000).

Resilience of Women in Adverse Situations

Wagnild and Young (1990) define resilience as an individual's ability in the face of overwhelming adversity to adapt and restore equilibrium to her or his life and to avoid the potentially deleterious effects of stress. It has also been described as the capacity for successful adaptation, positive functioning, and competence despite high-risk status, chronic adversity, and exposure to severe stressors (Wright, 1998). Resilience is a construct that encompasses both behavioral and psychological manifestations of competent coping with life conditions and events (Todd & Worell, 2000). In a study of resilience in poor women, one participant described resilience as the ability to keep going in the face of hardship or to face difficult times in life and still do "o.k" (Todd & Worell).

Researchers have examined resilient women in various adverse circumstances in an attempt to better understand the unique skills and abilities of some women to resist or reject the potential negative effects of adversity (Bachay & Cingel, 1999; Edward & Warelow, 2005; Humphreys, 2003; Leipert & Reutter, 2005; Todd & Worell, 2000; Valentine & Feinauer, 1993). Some of the characteristics which assist individuals to overcome adversity are considered to be genetic; however it is possible to strengthen these traits (Tusaie & Dyer, 2000). Characteristics such as optimism, intelligence, creativity, and humor have been found to assist individuals to thrive from and in adversity (Tusaie & Dyer). A resilient individual has an inner strength that helps her to bounce back from the problems that would seem to lead her to certain failure (Brokin & Coleman, 1996). Resilient women are characterized by: an active approach to solving life's problems; an ability to perceive experiences constructively even if these experiences have caused pain and suffering; an ability to gain other people's positive attention and support; a network of supportive adults within or outside the family; and a strong reliance on faith to maintain a positive view of a meaningful life (Wright, 1998).

Wagnild and Young (1990) found that older women described responding to a loss event by meeting it "head-on", keeping a sense of humor, and putting things in perspective. The women in this study described persistence despite adversity or discouragement. They had a belief in themselves and a belief that life has a purpose and that each person's life path is unique (Wagnild &Young, 1990). Felten (2000) also identified a strong will to survive and a refusal to be defeated as the key components of survival in a multicultural sample of resilient elderly women.

Elderly Jewish Holocaust survivors demonstrated resilience by being able to reach beyond their own experience, understand the pain of others, and express hope for the future (Lamet & Dyer, 2004). Studies of survivors of both childhood sexual abuse and spousal abuse described characteristics of personal competence, believing in themselves, and acceptance of self and life as key factors in surviving their abuse (Humphreys, 2003; Valentine & Feinauer, 1993). Several studies have reported that women recovering from abuse describe an optimistic world view and hope for the future as important (Lamet & Dyer; Humphreys; Valentine & Feinauer). In one study some women said that taking control of their life was the most important step; others said that it was important to take risks and to have goals (Valentine & Feinauer). The women described themselves as being leaders, and imagined themselves succeeding by taking small steps. They also saw themselves as victims; however they were able to perceive a better future.

Enhancing Factors for Resilience

Several factors have been identified which assist individuals to become resilient. Studies have documented a positive relationship between health and resilience, indicating that healthy women are more resilient (Felten, 2000; Humphreys, 2003; Wagnild &Young, 1993). Participants in one study related that self-care activities such as exercise, nutrition, and not smoking or drinking were useful in helping them experience resilience (Felten). In several studies women have mentioned that relationships to family or family like support, and having someone who believed in them assisted them to believe in themselves (Bachay & Cingel, 1999; Todd & Worell,

2000; Valentine & Feinauer, 1993). Support included helping with childcare and providing care for themselves during an illness. Todd and Worell (2000), however, found supportive social interactions unrelated to resilience. They acknowledge that this finding is contrary to the findings of many other studies on social support and suggest that their focus on low income women who did not have the freedom to choose with whom they interacted may have influenced their findings. They postulated that the members of the womens social network may have had equally stressful lives. Another interesting finding was that the comparison of oneself to less fortunate others was positively related to well-being. Women in several studies have said that it was important to offer support to other women to help give life a purpose (Felten, 2000). These women believed that doing for others enhanced their own well being.

Spirituality and religious values have also been found to be very important sources of strength for women in adverse situations (Bachay & Cingel, 1999: Felten, 2000; Todd & Worell, 2000; Valentine & Feinauer, 1993). Spiritual beliefs were viewed as important for providing personal comfort, meaning and balance. For Aboriginal women, spiritual beliefs put them in touch with their culture and with people who could understand and support them (Leipert & Reutter, 2005).

Resilient women have reported that critical life events involving losses or previous experience with hardship have made them stronger and acted as catalysts for change and growth (Bachay & Cingel, 1999; Felten, 2000). Several participants described their culture as part of an expression of themselves. Their way of life was based on cultural beliefs which were a source of strength and an aid in their process of becoming resilient.

In one study women felt that experiences with discrimination promoted their development of ethnic identity, while environmental or social factors such as language barriers and poverty deepened their strength of beliefs (Bachay & Cingel).

For Northern Canadian women of varied cultures, developing resilience included developing new strategies and enhancing existing ones, both behavioral and psychological (Leipert & Reutter, 2005). This process included: taking a positive attitude by downplaying the negative aspects of living in the north; sharing adversity and gaining perspective through humor and accentuating the positive by developing interests and activities that were possible and supported in the north. Methods to increase self-reliance included developing new skills such as learning to drive, or enhancing existing skills to counter isolation and limited options. These attitudes were important for the womens mental and physical health. The degree that women were able to develop resilience was affected by the degree of marginalization they experienced and by their personal resources including finances, social support, education and health. The women also used and developed resources and opportunities that were available in the north, for example, outdoor interests and local womens' groups (Leipert & Reutter).

Wright (1998) points out that both vulnerability and resilience should be viewed as relative and changing over time. Individuals who have the capacity for resilience can experience a loss of functioning and deterioration in health (Wright, 1998). The author points out that the exploration of factors that promote recovery and personal growth following stressful events may provide greater insight into processes critical to

resilience (Wright). If resilience is a result of a confluence of factors, it is likely that it varies over time, developmental state, and circumstances (Humphreys, 2003)

Mental Health Issues in Aboriginal Communities

The historical trauma of colonization and subsequent cultural oppression has resulted in disruption of the cultural continuity of First Nations communities and interrupted the passing of traditional teaching and practices (Bobet, 2006; Aboriginal Healing Foundation, 2005; Mignone & O'Neil, 2005). In an attempt to assimilate children the residential school system forced a traumatic separation of children from their families (Aboriginal Healing Foundation). Communities and elders were prevented from teaching their language and customs to the next generation and as a result cultural knowledge and pride was lost (Aboriginal Healing Foundation). Racism and reserve life have further reinforced the marginalization and cultural and spiritual alienation of Aboriginal people (Corrado & Cohen, 2003; Newbold, 1998). Many of the problems facing Aboriginal people today are a result of unresolved, multiple disconnections and historical trauma (Aboriginal Healing Foundation). Coping with the pain, a deep sense of grief, loss of identity, loss of spirituality and language have resulted in layers of mental health and addiction issues that have become intergenerational (Languedoc, 2006; White & Jodoin, 2003).

In Aboriginal cultures individual health and healing is integral to a balanced family and community life (Aboriginal Healing Foundation, 2005). Physical, emotional, mental and spiritual aspects are included in wellness, and health is always viewed in connection to the family and community (Bartlett, 2005). Traditional perspectives of

health did not separate mental health from other aspects of well-being (Bobet, 2006). Disruption of the traditional patterns have resulted in high rates of suicide, depression, and alcoholism in many communities, with the most profound impact on youth (Health Canada, 1996; Kirmayer, Brass & Tait, 2000). There are a disproportionate number of suicides, injuries, drug and alcohol abuse, sexual violence and some chronic diseases in the Aboriginal population in Canada (Adelson, 2005; Chandler & LaLonde, 2004). One Canadian study found that the rates of psychiatric disorders in Aboriginal communities were up to twice those in neighboring non-Aboriginal communities (Kirmayer, Brass & Tait). The incidence of depression, low self-esteem and substance use was higher in Canadian Aboriginal female youth than that of male youth (Stout, Kipling & Stout, 2001). Alberta Health and Wellness (2004) reported that First Nations people were 1.4 times more likely to seek health care for the treatment of an affective disorder [depression] than non-First Nations people, and seven times more likely to present to a physician's office for a substance abuse issue. Since estimates of the prevalence of psychiatric disorders are based on service utilization records and many Aboriginal people never come for treatment, the estimates are likely to be lower than the true prevalence in the community (Kirmayer, Brass, & Tait).

Health disparities including high rates of depression and suicide serve as indicators of distress in Aboriginal communities (Adelson, 2005; Kirmayer, Brass, & Tait, 2000). These indicators can be used to measure social, economic and cultural conditions (Waldrum, 2004). Although the socioeconomic conditions of First Nations people have improved, the unemployment rates are higher, family income is lower, and

crowded housing is more common than in the non Aboriginal population (Health Canada, 1996). Living conditions are poor and prospects for the future are few (White & Jodoin, 2003). There is a lag in the completion rate of all levels of education when compared to the non-Aboriginal Canadian population (Adelson). In Alberta in 2001 the unemployment rate for Aboriginal people was 14.9 compared to 5.2 for their non-Aboriginal counterpart. Median total income for Aboriginal persons 15 years of age and over was 13, 437 compared to 23,025 for non-Aboriginal Albertans (Statistics Canada, 2001). Many Aboriginal people live in over-crowded and under-serviced homes (Adelson). In 1991 the on-reserve registered Indian population averaged four persons per dwelling compared to less than three persons per dwelling for the non-Aboriginal population (Statistics Canada, 1991). These inequities in health and social indicators are manifestations of the complex interplay of social, political, and economic determinants that influence health (Browne & Fiske, 2001).

One of the largest disparities between First Nations and non -Aboriginal people is in suicide rates (Health Canada, 1996). In 1999 suicide accounted for 38% of all deaths in youth aged 10-19 and for 23% of all deaths in those aged 20-44, 2.1 times the rate of suicide in the Canadian population (Adelson, 2005). The Canadian rate is also reflected in Alberta where the suicide rate for Aboriginal youth fifteen to twenty-four years of age, was five to seven times higher between 1989-1993 than that of non Aboriginal youth (Capital Health Authority, 2003). Aboriginal women are three times more likely to commit suicide than their non-Aboriginal counterparts (Capital Health Authority). Respondents to the Royal Commission on Aboriginal People (1996) described an

epidemic of substance abuse and hopelessness that envelops young people and results in the highest suicide rates among [youth] in Canada. Aboriginal youth have been found to be at the greatest risk for suicide when they are experiencing events such as divorce, death, extreme difficulty at school, feelings of being overwhelmed and few or no social supports (Everall & Paulson, 2001).

Grief/Bereavement Following Suicide

Many studies report that shock, horror, fear, guilt, and feelings of blame are all characteristics of grief due to the loss of a loved one to suicide (Clark & Goldney, 1995; Diedrich & Warelow, 2000; Fielden, 2003; Ness & Pfeffer, 1990; Rubel, 2005). More than half of the respondents in a survey of survivors of suicide experienced crying spells, depression, deep unhappiness, apathy, or persistent anxiety, and several of the bereaved experienced suicidal ideation of their own (Ness & Pfeffer). The survivors of suicide are consumed with the question of "Why did my loved one complete suicide?" They feel guilt that they failed to identify the suicidal intent and intervene before the death (Clark and Goldney; Diedrich & Warelow; Fielden; Rubel). Suicide survivors were more likely than survivors of other types of death to assume responsibility for the loved one's death and to believe that they caused it or could have prevented it (Range, & Calhoun; Silverman, Range, & Overholser, 1994).

In their study of grief in South Australia, Clark and Goldney (1995) found that survivors of suicide suffered swift and large mood changes, depression, thoughts of suicide and severe and prolonged loss of self- esteem which could last for several years. A study of bereaved college students demonstrated that suicide survivors were more

likely to engage in self-destructive behavior than all other bereaved groups (Silverman, Range, & Overholser, 1994). Several authors have found that survivors are at risk of developing health problems due to high levels of stress and emotional pain (Diedrich & Warelow, 2000; Kalischuk, 2001). An increased incidence of substance abuse by survivors has also been reported (Rudestam, 1992). Eventually most survivors are able to tap into their innate strengths and coping capabilities to make the changes that are needed in their lives (Fielden, 2003; Kalischuk), although survivors may never fully resolve their feelings of grief (Ness & Pfeffer, 1990).

Families may experience a feeling of stigma following the suicide of a loved one and as a result they may feel reluctant to disclose the true cause of death (Clark & Goldney, 1995; Diedrich & Warelow, 2002; Rubel, 2005). Research findings indicate that suicide survivors experience higher levels of shame and rejection than do other bereaved individuals (Silverman, Range, & Overholser, 1994). Half of bereaved survivors in one study felt that a suicide in the family would be stigmatized, and were not willing to discuss it with others (Ness & Pfeffer, 1990). These behaviors may result in families feeling isolated in their grief.

Summary

The residential school system and cultural and political inequities have contributed to the marginalization of Aboriginal people in Canada. There is clear evidence of high rates of mental health problems in Aboriginal communities. Many people suffer loss and grief as a result of the cultural disruption. This has led to high rates of depression, alcoholism, substance abuse, suicide, and violence in many communities. Suicide has

particularly affected youth with rates that are much higher than non-Aboriginal counterparts. Disturbingly high rates of suicide in the community result in many families suffering the loss of their youth. Suicide is especially difficult due to stigma and subsequent loneliness and feelings of isolation. The remaining family members are at risk of unhealthy coping strategies or even their own suicide.

There is a substantial body of literature that focuses on resilience and grief following suicide; however no studies focused on resilience in Aboriginal women following the death by suicide of a loved one. Therefore, the purpose of the current study was to explore resiliency in Aboriginal women following the suicide of a family member. The following research questions were identified for the study:

1. What is the experience of Alberta Aboriginal women following the death by suicide of a loved one?

2. How do Aboriginal women cope during the grief recovery process?

Resilience is defined as an individual's ability to adapt and restore equilibrium to her or his life and to avoid the potentially deleterious effects of stress in the face of overwhelming adversity (Wagnild & Young, 1990).

Research Design

This study was conducted within a holistic framework that is congruent with Aboriginal beliefs of health. A participatory action research (PAR) design using a qualitative descriptive methodology was used to explore resilience in Aboriginal women following the loss of a loved one by suicide. PAR is an appropriate design for research with Aboriginal communities (Fletcher, 2003; Kaufer, Commanda, Elias, Grey, KueYoung & Masuzumi, 1999; McLeod, 1997; Patterson, Jackson, & Edwards, 2006; Smylie, et al. 2003). The design provides a flexible, socially and culturally acceptable framework that emphasizes the process of collaboration and the formation of partnerships with the participants in the research (Mill & Ogilvie, 2003). PAR is used to bring about action in the form of change, and to develop further knowledge (McTaggart, 1991). The PAR approach stresses the relationship between the researcher and the community, the direct benefit to the community as a potential outcome of the research, and the community's involvement in the process. Participatory research can be health promoting by enhancing resiliencies that exist in all communities (Macaulay, Delormier, McComber, Cross, Potvin, Paradis, et al, 1998; Macaulay, Commanda, Freeman, Gibson, McCabe, Robbins, et al. 1999). In the current project, the strengths and positive developments in the women's lives were emphasized in keeping with Aboriginal perspectives and beliefs about health (Dickson, 2000; Stout, Kipling & Stout, 2001).

The approach that was used in the current study is consistent with the principles developed for research with Aboriginal Communities (Alberta Mental Health, 2006;

Castellano, 2004; CIHR, 2007; Macauley, et al. 1998; Smith, 2005).These principles include:

1) Recognizing and respecting the right of the community to make decisions about research in the community. Incorporating the cultural values, perspectives and wishes of the community and emphasizing community empowerment.

2) Clearly defining the roles of the partners who are collaborating.

3) Ensuring that the community has access to the results of the research.

The implementation of the study was guided by the researcher's extensive experience working in the Aboriginal community as a community health nurse. She was familiar with the community and the beliefs. This experience allowed her to gain insight into the culture, to develop an awareness of political issues, and to develop relationships based on mutual trust. The issue of resilience in women following the death of a loved one due to suicide was identified by and explored with community members who affirmed the benefit of the research prior to the beginning of the study. Following ethical approval, a community advisory group composed of community women was established. An Elder was consulted prior to and during the study. The group recognized the contributions of both the researcher and the community members within an atmosphere of mutual respect. Clear expectations were established for the researcher and the committee. The results of the study were reviewed with the advisory committee following data analysis and prior to dissemination.

Target Population

In 2001, 3.8 percent (112,792 individuals) of the total population (2,855,029), of Alberta were First Nations (Alberta Health and Wellness, 2004). The target population for this study was First Nations women living on the Central Alberta Reserve of Hobbema. Hobbema has a population of approximately 12,000 people, with a cultural heritage of Plains Cree.

Data on the number of suicides per year in the community was not available to the researcher; however, statistics for suicide in Canadian First Nations people between 1989 and 1993 identified a rate of 80.7 deaths per 100,000 per year in the 15-24 age group and 49.9 deaths per 100,000, in the 25-44 age group (Health Canada, 1993). Based on this data the number of suicide deaths per year in Hobbema residents between 15 and 44 years was estimated to be 6-10 per year. It is also known that many suicides go unreported and are not included in the mortality statistics (Health Canada) and therefore it was expected that the number of suicides annually in Hobbema was much higher than reported.

The inclusion criteria for the study were women who: agreed to participate; were Aboriginal; were over the age of 18 years; had experienced a suicide in their family during the last ten years; and demonstrated resilience in grief recovery. Criteria for resilience was defined by the community advisory committee as women who "had learned a lesson". Potential participants were identified by the committee members and the key informants on the basis of their demonstrated characteristics of resilience. All of the women were First Nation and resided in the reserve community. Although many

families had experienced suicide in the last ten years, some may have chosen not to participate due to the sensitive nature of the topic.

Data collection methods

Following ethical approval, five community women were invited by the researcher to participate in a community advisory committee. The committee included a community health representative, a teacher, a former counselor, a community member who had lost a loved one to suicide and an elder (see Appendix A). The tasks of the committee included developing a definition of resilience for women in the community, exploring cultural beliefs of suicide in the community, and providing feedback on the information letter, consent form, and guiding questions. The community elder was approached using the correct community protocol to request guidance in conducting the research in the community. The elder was given a gift in appreciation of her time. The researcher was assisted by professionals in the community who were knowledgeable about the culture and had a special, ongoing relationship with the researcher. They included a community health representative, community health nurses, and mental health counselors. A purposive sampling technique (Polit, & Beck, 2004) was used to recruit women who resided on the Hobbema reserve and who had lost a loved one to suicide. This sampling strategy enabled the researcher to recruit participants who were judged to be particularly knowledgeable about the issue under study (Polit & Beck). Women were chosen as participants in the study because they are "…the backbone of the Aboriginal family, they have to keep the children and the husband, they are the ones

that must nurture their family through thick and thin; they are like trees that branch out and nourish their family" (Otter, V. personal communication as taught to her by her grandmother, February 25, 2006). The professionals who assisted the researcher discussed the study with clients who met the inclusion criteria. They then provided an information letter to potential study participants (see Appendix B). The letter described the study including the time commitment, the potential risks and the benefits to participants and the community. The letter also included the researcher's name and contact information. Once the participants agreed to participate in the study they were contacted by the researcher and consent to participate in the study was obtained (see Appendix C). The researcher was known to the community and had established professional credibility through many years of working in the community.

The primary method of data collection was in-depth interviews. Interviews are congruent with the storytelling approach to sharing Indigenous knowledge (Smylie et al. 2003). Recreating experience through storytelling has been found to be particularly relevant to the study of grief (Gilbert, 2002). A preliminary list of guiding questions (see Appendix D) was developed by the researcher in consultation with the community advisory committee to ensure that all aspects of the experience were explored. The questions were open-ended to allow participants freedom to share their stories. The guiding questions were refined as the interviews progressed. The researcher attempted to elicit participants' thoughts, feelings and actions based on their personal experience of grief recovery.

The interviews averaged 1.5-2 hours in length and were conducted between July and December 2007. Ten women each participated in two interviews for a total of 20 interviews. A total of 20 were conducted by the researcher over a 6 month period. The interviews took place in the participant's home or a private place of the participant's choice to ensure the comfort and confidentiality of participants. The researcher was familiar to most of the participants. This helped to increase their comfort in having the researcher in their home. Interviews were audio-taped with permission from the participants and transcribed verbatim by an experienced transcriber. Each participant was interviewed a second time to provide the opportunity for participants to clarify and validate data obtained in the first interview and the emerging themes. The second interview also provided an opportunity to provide additional information.

Following each interview, field notes were recorded by the researcher to document information and also to synthesize and understand the data (Carmen & Profetto-McGrath, 2004). Field notes described the observed events and conversations that were made in the field and the researcher's interpretation of those observations. Memos were used by the researcher to identify her own biases and to detail how she was influenced by the interviews (Field & Morse, 1995). This was important to establish an audit trail that could be checked by an independent auditor (Morse & Field). The credibility of the research is enhanced when investigators describe and interpret their own behavior and experiences in relation to the experiences of the participants (Sandelowski, 1986). Representativeness of the data and coding categories was established by transcribing the interviews verbatim to ensure accuracy and by reading and rereading the data to develop

the codes. This ensured that the perspectives of the participants were reported as clearly as possible (Morse & Field).

Data analysis

Data collection and analysis occurred simultaneously as soon as data collection began (Polit & Beck, 2004). The researcher compared the written transcripts with the taped interviews to ensure accuracy. This ensured that the perspectives of the participants were reported as clearly as possible (Morse & Field, 1995). The interviews were then analyzed to identify emerging themes. Themes are significant concepts that link portions of the interviews together (Morse & Field). A categorization scheme was developed of underlying concepts after careful reading and rereading of the data. Data were coded according to the categories developed. The categorization scheme was revised as necessary as themes were discovered that were not included in the initial category system. The interviews were then entered into the software program QSR N6 for analysis. Field notes summarizing the entire interview were kept to enable the researcher to identify common themes, to identify her own biases and to detail how she was influenced by the interviews (Morse & Field, 1995.The emerging findings were shared with research participants during the second interview for feedback, correction and validation (Carmen & Profetto-McGrath, 2004).

Rigor

Care was taken to ensure that the research methods were appropriate for the community in which the study was taking place. In order to establish and maintain rigor in the current study a framework was followed that utilizes eight criteria proposed by

Meleis (1996). The eight criteria include: contextuality and relevance; communication styles, awareness of identity and power differential, disclosure, reciprocation, empowerment and time.

Contextuality and Relevance

Knowledge of research participants' lifestyles and situations is essential for developing the research questions and for understanding the meaning of the results (Meleis, 1996). Context and relevance are increased by prolonged contact with the participants (Morse & Field, 1995; Sandelowski, 1986). Mill and Ogilvie (2003) found that a visit to the community prior to the beginning of the study fostered their understanding of the relevance of the study for their population. In the current study the researcher's familiarity with the community helped her to understand the stories of Aboriginal women who had experienced the suicide of a loved one. Relevance is also related to the extent to which the research problem and questions are considered significant for the population and meaningful for them (Meleis). Relevance was established through discussions with community members prior to the initiation of the project. It was enhanced by the participation of the community advisory committee and elder.

Communication styles

Researchers must demonstrate critical understanding of preferred communication styles for the research participants and their communities (Meleis, 1996). Interviews were chosen as the method of data collection because they are the most similar to the community preferred communication style of storytelling. The advisory committee was

consulted to check for in-depth understanding of language and meaning throughout the research process (Meleis, 1996). A second interview was held with each participant to confirm understanding of meaning of the first interview and emerging themes.

Awareness of identity and power differential

Consenting to a research project is meaningful when there is less distance between the researcher and the participants and when there is reasonable chance that the participants can exercise the power to dictate the research questions or to refuse to participate in the research project (Meleis, 1996). Participants were invited to participate by a key informant who was familiar to them.

Disclosure

It is essential to present the marginalized populations' experiences in ways that are authentic to the narrators and understandable to the audience. The fact that the researcher was known to most of the participants increased trust, however, the relationship was not equal in power. This may have limited participants' ability to not respond to questions if they had preferred not to.

Reciprocation

One of the goals of a culturally competent research process is to ensure that all parties involved meet their own goals from the research process and through the research findings (Meleis, 1996). Through the interviews the researcher was able to gain a better understanding of how First Nations women cope and heal following the death of a loved one to suicide. The participants were able to tell their story to an interested person and to gain insight into their own healing process.

Empowerment

The research facilitated empowerment of the advisory committee and the participants by raising their level of consciousness during and after the study (Meleis, 1996). The members of the advisory committee and the participants were able to relate to the research project and expressed interest in the results of the study. They were interested in learning about healing strategies that were successfully used by other women in similar circumstances. They have also expressed interest in using the findings to develop community support groups. Two of the participants expressed interest in conducting research of their own by patterning the current study. Presentations to community groups enhance the rigor of the research by validating the experiences of the study participants (Mill & Ogilvie, 2003). In the current study validation of the findings was enhanced through member checks during the study and presentations to the advisory committee and community groups at the conclusion of the study.

Time

A flexible schedule of timing for interviews, adequate time allotment for the interviews, and a comfortable place to conduct the interviews helped to build trust with the participants.

Ethical Considerations

The project was approved by the Health Research Ethics Review Board (Panel B) of the University of Alberta for approval prior to the commencement of the study. A letter of support for the study was provided by the Hobbema Mental Health Services

(see Appendix E), and Louis Bull Band [one of the Four Nations Bands of Hobbema] (see Appendix F). The consent was reviewed by the community advisory committee to ensure that the consent was easily understood and culturally appropriate. The participants were informed of the overall goal of the study in an information letter (see Appendix B) which was distributed to them by key informants. Participants were assured that their privacy would be protected and that their information would be kept confidential. Participants signed a written informed consent prior to participating in the study. Numbers were assigned to the transcripts by the researcher and original names were kept separate from the transcripts. All information kept on a computer was password protected to ensure confidentiality. Documents are kept in a locked filing cabinet and will be shredded after five years.

Participants were told that their participation was voluntary and that they could withdraw from the study at any time. A primary benefit of the study was the opportunity for participants to express their feelings regarding the loss of their loved one. The participants also had the opportunity to participate in a study with the potential to identify interventions to support Aboriginal women in the community to develop resilience. They were also advised of the risk of emotional trauma that could occur through reliving the experience of loss as a result of participation in the study. Arrangements were made for referral to a counselor in the Hobbema Mental Health clinic in the event that this was required (see Appendix E).

Findings

The study sample included ten women who demonstrated resilience following the death of a loved one. Eleven women were recruited however one woman chose not to participate. During the process of setting the appointment it was determined by the researcher in discussion with the prospective participant that she was not yet prepared to tell her story. This woman visited the researcher later to discuss the study and to learn what had been found to be helpful to the study participants. The women ranged in age from 19 to 64 years old, with a mean age of 46 years. One woman lost her husband, one her daughter, one her female cousin, three lost sons, two lost boyfriends and two lost brothers. Collectively the woman suffered the loss of 22 loved ones to suicide with 9 women having lost more than one family member.

The focus of this study was to understand the experience of Alberta First Nation women following the death by suicide of a loved one and to learn what helped them to cope during their grief recovery process. Eight participants lost male loved ones while two lost young females. Nine of the participants loved ones died by hanging; the tenth died by shooting. The age range of the individuals who ended their lives was 16-44 years and most of the individuals were under 25 years old. Two of the deceased individuals were in a marital relationship with the survivor; the remaining eight were single or had recently been involved in a relationship break-up. Aboriginal people who die by suicide are more likely to be male, young, and single and the suicide is often carried out by the highly lethal means of guns and hanging (White & Jodoin, 2004).

Following consultation with members of the community advisory committee pseudonyms were assigned to the women. Pseudonyms help to protect the participant's identity and increase the reader's ability to relate to the women's experiences.

Participants

Angie is 36 years old. She volunteered to participate in this study as soon as she heard of it. She had lost a number of close friends and relatives including a cousin who was very close to her. In this study she shared her experiences following the death of her first steady boyfriend in a suicide by shooting 20 years previously. Angie had a very difficult time coping with her losses and the interview was the first time that she had talked about the suicide death of her boyfriend. She brought her young daughter with her to the first interview and her niece to the second because she wanted them to understand the impact of the loss for survivors. Her niece had attempted suicide several times previously. Since the interview Angie has lost another nephew through suicide who was very close to her.

Mary is 62 years old. Three years ago she lost her 29 year old son by hanging. They had a very close relationship. She feels that she is just starting on her recovery road. She mentioned that boarding school was another very difficult time in her life and she still becomes emotional thinking about it. After both interviews were completed Mary shared with the researcher the diary that she had kept following her son's death. She said that talking about the death helped because she was scared to go to grief recovery. She thought she would break down.

Lucy is 64 years old. Fifteen years ago she lost her 17 year old son by hanging. She said that she was nervous to participate in the study. She said that she was "scared to talk about it" but she wanted to help other people and help herself by getting something out of it, because she could never talk about it. The interviews were done in the researcher's vehicle because Lucy did not have a private place to talk.

Betty is 63 years old. She lost two brothers and her nephew to suicide about eight years ago and two brothers to accidents. She said that if she was able to help even one person by telling her story it was worth it. Betty felt grateful for the chance to talk about the deaths and she said that after the first interview she was able to talk about her losses to other family members.

Martha is 56 years old. She lost her common-law husband to suicide 14 years ago. She said that when the study was discussed with her she felt that she needed to participate because she was born and raised in the community and she realized the importance of sharing the information. After the interviews Martha said that she felt exhausted because she had never told the story in it's entirety before.

Lillian is 55 years old. She lost her oldest son 22 years ago at age 16 to an accident, her 2nd son 4 years later at age 16, her 3rd son eight years ago at age 21. Lillian had also lost a nephew to suicide and her brother and her husband through murder. Three of her losses occurred within six months of each other. She had heard about the study and referred herself. Lillian was willing to participate in the interviews because she felt that she could share her experiences with others who had also lost a child. She

had been interested in starting a support group for some time and she hoped that the study might help to establish a group

Patricia is 35 years old. Thirteen years ago she lost her cousin who was like her little sister. Patricia also had many other family losses. She said that she likes to do her part to give back to the community, however says that she "doesn't share her experience most of the time because most people are uncomfortable hearing it".

Amy is 33 years old. She lost multiple family members to suicide including her mother, four brothers and her best friend. Another brother was killed in an accident. She said that doing the interviews was "a relief " because it was stuff that she hadn't talked about in a long time . She said that it felt good to "let it out., like a weight was lifted".

Kathy is 19 years old. She lost her best friend, a boyfriend and her common-law husband to suicide. Her husband died at age 18 about two years ago. His death is the loss that she talks about in this study. Kathy said that doing the interviews were "hard but good" for her.

Cara is 46 years old. She lost her 20 year old daughter 14 years ago to suicide. She had also lost other family members to suicide including her cousin. The key informant who told Cara about the study described her interest in participating as an "urgency". She said that she wants so much to see "changes in the community".

The participants were given the opportunity to tell their "story" during in-depth interviews. They usually began their story by relating the suicide death of their family member. The women described the experience of losing a loved one to suicide as the most difficult, devastating experience that they had ever gone through, so difficult that

sometimes they "could not even put it into words". Martha tried to express what the experience of losing her husband was like for her:

> *It was the most horrifying, brutal, devastating experience I ever have gone through. Something that is forever gone and I'm never going to see him. But of course, I never forget.*

Many of the women in the study had experienced multiple losses in their lives. The losses were close friends or family members and most of the losses were due to suicide. Patricia said that throughout her life she had been surrounded by death. She said that at age 35 she didn't want to list her losses because they would fill a whole page. Angie said that she had lost ten relations through violent deaths, most of them suicide. Betty had lost three brothers in six months and at the time she wondered how she could get through it. In the current study, the women described their closest loss. Amy had lost several family members to suicide:

> *Well, I guess it all started when I was 11. I had lost a brother to suicide, a year later, my best friend hung herself, and it was shortly after my birthday. I had just turned 12. And then 3 months after, another brother had passed away, but his death was due to a motorcycle accident. And then the next year, the youngest of my brothers shot himself, and it was at our home during the night, so we were dealing with this in the early hours of the morning. I had another brother who apparently shot himself when I was only about a year old, so I never knew him. So I had the two brothers left. Then one of the two committed suicide 12 years later, the day after his birthday. My mom passed away . I often question her death, because I had experienced a couple of times where she'd be drinking, and she talked about suicide. It got to a point where I'd try my best to keep her in the house; I'd lock her in. So when she died, I thought - like, in my head, it wasn't an accident. So I don't know if hers was accidental, or if she did commit suicide. Those are the ones closest to me that I lost through suicide. I guess when I was growing up, going through teenage life, I guess I grew up fast.*

Several participants in the study indicated that they had a premonition or feeling of knowing about the death before the event actually happened. Lucy said that while

they were looking for her son she had a feeling that she was never going to see him again. Cara said that at the time of her daughter's death she felt a pain "right in my heart". She had been dreaming and saw a funeral and a wake with a lot of cars. Amy recounted the feeling that something was going to happen to her brother:

> *I remember thinking and feeling like something was going to happen. I remember thinking that I was going to get a phone call. And sure enough. I knew it was coming; like, I felt it coming ... I remember feeling that if it was going to happen; it was going to happen soon. And then by the next morning, he had already shot himself.*

Reacting to the Loss

Disbelieving "No words to describe"

Many of the women described their initial reaction as shock, horror and disbelief. Cara said that when she was told her daughter had died she just didn't believe it. She said that she "didn't lose it or go frantic". She just kept walking around not knowing what to do. At first she did not want to go to the place where her daughter had been found. Martha described her initial reaction upon hearing that her husband had died:

> *"What happened?" "He hung himself." "Where is he?" He didn't make it. And that was the MOST worst, worst - I can't describe that second. It seemed like I was in this darkness. I lost it; I lost it. I cried. Not one word in the English language will describe that feeling. But from that second, from that news to until, like, trying to make some sense of this event, I can't tell you - I can't tell you what happened I was in this - I was so weak- my - I can't describe that horrible - I guess it's the shock, the horror, the despair because I was so, so devastated [pause] because my soul mate, my best friend, my pillar, my strength, was nowhere; he was gone.*

Some of the women described being in a state of shock after being informed of the suicide. They were walking around but not really aware of what was happening. Lucy, whose son died, did not remember what happened after she was told that her son had been found:

My brother said, "I found him." And he dropped me off at the house. That's as far as I remember. I got out of the truck, but I don't remember anything after that. I guess I just was walking and just hitting everything. I guess I fell, and they got an ambulance for me. I didn't remember anything till late that evening. Through the week, I just remember - like, I don't remember who was there. I don't even remember my kids or my husband was there. I don't remember anything at all through that. So that part, till they buried my son. Seeing him put in the coffin, that's when I started remembering again, remembering all the people, a lot of people.

Withdrawing "Keeping the distance"

Many of the women mentioned that they withdrew as an attempt to try to cope with their indescribable loss. For some this meant a physical or emotional withdrawal to remove themselves from the situation. A few women mentioned taking time off work and going on a trip, while others mentioned spending time with family in another location. Mary said that she thought that it might help to leave home; she said that it helped a little bit but the pain was still there. For others withdrawal meant retreating into themselves, blocking the suicide out and sometimes blocking others out. Martha said that when she lost her husband she didn't want to be present to make the funeral arrangements. She said that somehow she needed to find the strength to withstand that "horrible, devastating loss":

I had left my home for - for a good 2 months. .....I had left my home. I didn't want to - I didn't have the strength - I'd go there, but I just couldn't handle it. So I said, "Let's just not deal with it right now."

Mary said that she didn't want anybody to comfort her; she just wanted to be on her own. Cara said that after losing her daughter she went through the motions of life but she felt that " it still wasn't me". Lillian said that she would go to work, go home, and go to work again. She said that she isolated herself for 7 years. Another woman said

that she tried to keep the death hidden and not talk about it. Patricia talked about her experience of going through the motions of living after losing her cousin:

> *No one talked, we just went through the experiences and continued to live.... and it was just too over - I wasn't even - I didn't even feel like half of the time it was like I was there. I wasn't feeling myself, or really me experiencing my experiences. I was just a little bit like a zombie at times. And I would trance out a lot.*

A number of the women talked about their family being separated or torn apart in their grief. There was so much pain in the family that every one went their separate ways instead of coming together in support of each other. Betty said that she just created a barrier around herself and the other family members did the same. They each grieved on their own. Martha said that her sisters could not stand to see her in so much pain. A few of the women talked about other people withdrawing from them because the death was due to suicide. Lillian initially thought that people were keeping their distance because they blamed her for the death and she felt very guilty herself. Later, she understood that her friends just didn't know how to help with the grief. She had lost sons through suicide and accidents and she talked about the difference between the two losses:

> *I think right at that point in time when you lose somebody, there's that very alone feeling. It's like you're the only one that's going through this. And people - after you've lost somebody, more so through suicide, people are scared to talk to you. It's like they shy away from you. And sometimes I wonder, I think it's just that they don't know what to say.... Yeah, that's what I found out, and it's different when I lost my sons - 'cause I lost two through suicide and two through accidents. So when I lost the two through accidents, it was different compared to the two through suicide, how people kind of shied away from me when it was the suicide. Like I was saying, everybody just kind of kept their distance from me. And I know for a fact it had to do with just being - not knowing what to say, not knowing how to act.*

Questioning "What Triggered Him Off?"

A very consuming question for all of the participants was "why"? The women said that the question "why did they take their own life" was one of the first things that came to them. The thoughts were described as "churning in my mind". The suddenness, the finality, and the inability to say goodbye made the loss so harsh. Many of the women were still struggling to make sense of their loss many years later, although most of them were reconciled to the fact that there were no answers and they would probably never know the reason. When speaking about her final evening with her son Lucy shared:

> *And he just kept smiling. He said, "Today, I become a man." That's what he said. And that night, he committed suicide. I don't know what triggered him off, what made him mad. I don't even know if he was mad, or maybe just peer pressure from the school or from his friends, that I will never know, what triggered him off to do it. To this day, I don't know why, why he did that. He just got up in the morning, shot himself. We didn't - no letter, no nothing, no good-byes.*

Several of the mothers who lost their children to suicide wondered if the death was punishment from the Creator for something that they had done or not done. Lillian felt that losing two sons was punishment for the lifestyle that she had lived. Lucy had also lost her son and asked the Creator every day to be forgiven:

> *I asked the Creator EVERY DAY, I smudge and pray, "If I did anything wrong, or did to my son to make him commit suicide, I want to be forgiven." 'Cause I don't know why, and I guess I'll never know why he took his own life.*

Two of the mothers were fearful of where their deceased children were. Cara said that she had asked "where is she?" but realized that it was a question that nobody could answer. Mothers wanted their children to be in a good place because they loved them so much, but they were afraid that they would not make it there. They felt that they had to know where they were. Two of the mothers mentioned a cultural belief that frightened them. Cara explained her distress:

I don't want to believe a story of when people commit suicide that they're always in the dark, and they're in the dark until the time comes when they're really supposed to go. I don't believe that story. I believe she went to Heaven. I just believe that.

Hurting "Part of me was gone"

Participants described the profound emptiness and pain they had initially felt. Many mentioned that they relived the pain during the interview. A few participants said that they were tired of feeling the pain and just wanted the hurt to go away. Martha, at the height of pain, described herself as being "just broken". The memory was still vivid and it evoked the same sensation of pain as when her husband died. The women were able to remember every detail about the time of their loss. Angie said "I could just feel it in my chest", and another said that a part of her just ached. Lucy said that she felt like a hollow person after the loss of her son feeling "part of me was gone". Mary lost her son and said that she will probably never forget him because she thinks about him all the time; when she wakes up in the morning and when she goes to bed at night. Cara described the pain she felt when she talked about the loss of her daughter:

I think I don't want to feel the pain, but I know it's still there. Mainly, I think what I hear about is or what I feel is, in my stomach, when I talk about the loss of my daughter, what I do is sometimes - sometimes I do just get sick to my stomach and I just want to cry when I'm going to say something about losing my daughter. I think that's the biggest loss

Angie remembered the details of the event 20 years later.

Yeah, just thinking about it. I think its part of me wanting to let go now, because it's been, like, 20 years; it's been about 20 years in March - no, in April, it'll be 20 years - April 9, 1986. Oh, I just know the day and the time, 10:30 in the morning; I just know the day and the time. Even though it's been that long, I still remember. I remember what I was wearing and everything. And people say stuff like that, you really don't think about it, like, the small details. If somebody was to ask you, like, 5, 10 years down the road, in the back of your mind, it's still there, even the smallest detail.

Not taking care "Withering Away""

In addition to the pain, the women also described other physical effects of grieving. Some of the women said that they didn't care what they ate following the suicidal death. Many of them described weight loss and difficulty sleeping. A couple of the participants said that they put on a lot of weight, however others said that they lost weight. Lillian said that when she lost her son she didn't care about eating; she just didn't care about herself enough to make sure that she ate at least one meal a day:

> *Sometimes, later on when I thought about it, there was days I went without even eating, and it didn't matter to me.*

One woman said that she drove her family crazy because she couldn't eat and couldn't sleep; she said that she was driving everybody crazy and at the same time she was "going crazy herself". Mary said that she had aged through the grieving:

> *I had lost weight because of my grieving. Friends used to freak out on me, and say, "How come you're so skinny?" I really went down. I think that's another thing; I noticed I really aged, 'cause my face, like, it's chapped here; I guess 'cause of my crying.. Oh, yeah, I lost sleep, too. That first year, I didn't sleep good. I had to go ask the doctor to prescribe sleeping pills.*

Several of the woman said that the actions of taking care of themselves were a chore, a duty. They talked about sleepless nights and the difficulty eating and performing self care like showering and dressing. Lillian described what her days were like for her:

> *Then there was days that I just wouldn't even shower up or anything, or even change; I'd be in my nightgown all day long. Like, that could go on for 2, 3 days, and it's like I just didn't give a damn; you know, I just didn't care one way or the other about my appearance or anything. And that was because I was so stuck in that self-pity; like, it was "Poor me," and "Look at what happened to me," and it was, like -. And sometimes I think it was because I was so stuck in that that I failed to see*

[pause] what could happen. And sure enough, 4 years later when my other son was 16, that's when he committed suicide.

Crying "A river of tears"

All of the women talked about crying intensely initially, sometimes for days at a time. One participant said that she cried "*a river of tears*". Mary used crying as a yardstick to measure her progress toward healing:

Most of my crying bouts went on for a few days: I cried lots, cried. The first year, I think - I'll say, for one year, I cried. Whenever I thought about my son, I cried. For one year I cried; I don't know how many times a day I cried cause I kept crying all the time. Even when my husband and I are talking about him, I'll cry... When everyone was sleeping, I'd get up, and I'd just bawl. I'd just cry. I would sit down on the chesterfield ...and I just cried and cried. I don't know if I cried for 10 or 15 minutes right there, just bawling... I don't cry the way I was crying, hard. Before, I used to cry, it was like I don't know, sobbing and just crying. Now, all I have is tears, I'll shed a tear and I'll cry. Not the way I used to cry.

Later on the women recognized that crying was healing and that it was better for them than "holding it in". For some of the women this caused a conflict in that they had been taught not to cry for "the ones who have passed away". Amy discussed learning to give herself permission to cry:

I have learned that it is, (cultural) and I have learned to disagree because after a good cry, man, did it feel good! I had to learn how to cry and to give myself permission. I have grown from not crying and holding it in and getting frustrated and angry, to giving myself permission to just cry. And sometimes, I still struggle with that; sometimes I just don't want to cry, but yet it's healing. So I always have to give myself permission, and then once I let it out, it's a big sigh of relief. It really does feel like a whole pile of weight has been lifted.

Regreting "I should have, I could have..."

Several of the participants expressed regrets for things that they wished they had done or said. Cara regretted not taking her daughter's threats seriously and wished she had listened to the counselor. Betty regretted telling her nephew to move out. Kathy lost

her boyfriend and she regretted not having been able to tell him that she was pregnant. Martha lost her common-law husband and she regretted that they had not married:

> *Like, he was wanting to get married in the hospital. Then another comment like, "What about" - 'cause I wanted a well planned family-friends gathering when it happened, and then his suggestion was, "Why don't we go see a JP and then have a big meal after?" But no, I wanted the - of course, it didn't happen. I guess for a while there, I had a hard time with that. That would go into one of my regrets.*

Most of the participants expressed strong feelings of guilt that their loved one had committed suicide. They felt responsible for the death, and it took a long time to forgive themselves. Many blamed themselves and some felt that if they had been better mothers the suicide would not have happened. They felt that if they had paid attention they would have been able to read the signs and prevent the death. Some said that they started playing back the things that they could have done to prevent it. A girlfriend felt that she had caused the death by making her boyfriend chose between her and another girl. Mothers who lost children felt that they had been bad parents by actions such as not telling their children often enough that they loved them or by disciplining them too harshly. One mother thought that she did not teach her son properly about "the good things in life". Another mother who lost two sons felt that she had neglected her children by using alcohol and by not being there for them. Some of the mothers also felt that other people were blaming them for the death of their family member. Lillian talked about torturing herself with guilt:

> *"I should have, I could have," you know, all those all those things that I thought I should have done, I could have done better to stop this from happening. I really tortured myself, I really punished myself... And for a long time, I blamed myself.*

Infuriating "Mad at the World"

About half of the participants talked about feeling angry and bitter. Martha talked about at first being angry with her husband for leaving her so suddenly:

> *Then, of course, during the grieving period, there was much anger. I was angry at him for leaving so suddenly; you* know- *But I allowed that, I allowed myself to get angry for a while.*

Lucy said that she was "so mad at the world", while Mary was very angry at God following her son's death:

> *At first, I was mad at the Lord. Why did He take him? After I just finished praying that morning, and - that's what I can't understand; sometimes it really bothers me when I really think that I just finished praying that morning, and still, I lost my son.*

Another mother also expressed anger at God. She said that she could not pray for a long time following the suicide:

I was bitter for a long time. For a long time, I couldn't pray. I would yell and say, "You're a kind, loving God! You call Yourself kind and loving? Lies." You know, "All those lies." I had no answer for it.

Other participants mentioned having felt angry at other people. A few blamed people who they felt contributed to their loved ones death. A mother felt that if her son's girlfriend had disclosed a suicide note maybe his suicide could have been prevented. Lillian felt that her husband's murder contributed to her son's death by depriving her son of his father.

Fearing Another Suicide "Can't let him out of my sight"

Most of the women spoke of being fearful of another loss. Two of the women who had lost partners had not started another relationship. Martha who lost her husband 14 years ago said "I haven't shut the door on that but I'm just not ready to choose". Angie said that it took her a very long time to trust a man because of the fear of being hurt.

Mothers who had lost children spoke of being very fearful of losing another child. They found themselves being very protective of their remaining children. Lucy described her fear:

> *After my son committed suicide, I was so afraid, I wouldn't let my (other) son out of my sight. I was so afraid he was going to do the same thing. Then one day, my daughter said, "You know, you're going to have to let go of him. He's a man; he's a 30-year-old man." This was about 5 years ago when she told me that I was always hanging on to him. I had a hard time letting him go. "He's got a family of his own that he has to look after, he has to work. You can't keep him tied to your strings all the time. Can't be there all the time, watching over him. You have to let go."*

Lillian also described herself as being very overprotective of her remaining children. She said that she was suffocating them. Her surviving son complained:

> *"Holy shit, you don't even let us go play outside by ourselves". And I think that's when it really hit me, that even at my dad's, I'd be standing at the window, and I'd be just watching them. I wouldn't be visiting as I said I was going to go there to visit; I'd be standing at the window and I'd be just watching them, making sure that they were there. I was very over-protective of my children.*

The women expressed fear of losing their children and grandchildren especially if they had similar features or characteristics to those of the deceased. Lillian insisted that her grandchildren receive therapy to prevent them from "ending up being part of that" [suicide]. Cara said that now she listens very closely to her children because she is afraid to go through it again. Amy said that she has a hard time trusting now, and she fears that someone else close to her will die. She finds herself staying up if family is away and even phoning the hospital because she is afraid something has happened to them. Patricia also said that she is scared to lose someone else, "like my cousins, my uncles, or my dad".

Unhealthy Coping

Alcohol "Cause I felt really bad"

The participants talked about some of the ways that they had tried to cope with the pain of their loss. Several of the women said that they had tried to hold it inside. Angie, who had lost four family and friends in one year and ten relations altogether, said "we used to learn to hold your emotions inside; you'd just learn to stop feeling stuff, you'd see so much you just block them out." Many of the participants said that they just couldn't look after themselves and that they felt like they didn't care what happened to them. Other women used unhealthy coping strategies such as alcohol to try to ease the pain. Kathy who lost her baby's father said that the only time that she could let it out was when she was drunk. She drank every day "cause she felt really bad":

> *But after I had my daughter, I started drinking. About 2 months, 3 months after I had her, I started drinking a lot, and that's why I don't have my car.*
>
> *Angie said "from that day [boyfriend's suicide] I don't remember anything till about 9 months, around 10 months, I drank every day."*

Amy, who suffered many family losses said:

> *I guess I grew up fast, well, eventually, I did get into alcohol and ... Okay, I started drinking when I was 14 and continued on for - until I was 25. Then I ended up in a relationship very young, started having kids young, and [sighs] alcohol was still, I guess, a factor in my life.*

Patricia described her drinking pattern for the first year after she lost her cousin:

> *She was 19 when she passed away. From there on, I was - and I knew about parties and I began to drink. I think at the same time, I wanted help, I drank for a good year straight; actually, more than that. Yeah, a good year straight for yeah, a year. Starting from Thursday, Friday, Saturday, Sunday, and then I'd work, and then I'd start again, Thursday, Friday, Saturday, Sunday*

Drugs "Easing the Pain"

Two of the woman used pills to help them cope and to ease the pain. Patricia described herself as having been very athletic prior to her loss. She said that eventually she had her booze and a whole bag full of pills. Angie lost her boyfriend 20 years ago when she was 16 and she started using drugs because she was so hurt by his suicide:

> *That's why I turned to the pills so much, 'cause that was my, how would you say it, that was my way of easing the pain..- and I'm not just talking Aspirin or stuff, but really hard-core pills, ...that high it gave me and that peace of mind where it puts you, like nothing can hurt you; like, nothing can hurt me, nothing can touch me, that was that kind of high I was getting, so the more I took, the more numb I became, so I just stopped feeling. Not long after that, I met this older man, and he introduced me to hard-core; I mean, like intravenous stuff, morphine and coke and heroin, stuff like that. I never knew what that stuff was, and I used to tell myself I'd never, ever do stuff like that, ...Yeah. After a while, I didn't care; I just didn't care what happened. Didn't care no more. I think it was just 'cause I was so hurt, that was so hard. Like, I didn't know how to comprehend a suicide like that, especially somebody that close -, it's devastating; it's really hard...hard-core drugs. Just kind of set my mind, just kind of left, forgot about him; more or less just gave myself up to the drug.s*

Several of the participants acknowledged that they had to make a conscious effort to avoid drugs and alcohol following the suicide. For some of the women alcohol had once been a way of coping and the temptation was there to fall back on it. It would also have been easy to depend on pills because in many cases doctors prescribed medication for the women. They had to make a decision to avoid dependence on chemicals. Two of the women related their struggle to resist drugs and alcohol:

> *There was a little bit of me out there that was keeping an eye on me, so that I wouldn't resort to chemicals' cause I used to drink -I wouldn't go back to drinking, I wouldn't resort to pills because it's so darn easy when you're in that situation to get the doctors prescribing. As a matter of fact, the doctors... my medical doctor prescribed some of those little white pills; ... So after 6 months, I found those pills in my bag, and I guess out of 20, I had used 7 of those Ativans, and out of the 7, I used 2 of those pharmaceuticals. So I was able to go through this period without*

any chemicals. Of course, I thank the Creator for all of that, because it was so easy for me to get into that rut of prescriptions.

Martha

…it took some kind of a will power; Even that, that's the only time I ever had a real urge to go out and drink in all the years I've been sober, is after I lost – (my son) probably I'd have gone down the same road [suicide]. I probably would have done the same thing… to me, I look at suicide doesn't have to be -doesn't have to be - for me, even to start drinking would be going on that suicide road…I thought I should go drink. That's when I started praying harder that I'll be stronger.

Lillian

Two of the women mentioned the effect that negative role models had on them. They observed the lives of women who were dependent on chemicals and this served as a motivation for them to avoid the use in their own lives. Three of the women had reached the point of a psychological breakdown. They just didn't care about themselves and they couldn't be strong anymore. Patricia described her experience when she lost her cousin who was very close to her…

I ended up getting severely exhausted, and it happened one day … and I started crying. I started crying, and I couldn't stop crying. I cried and I cried and I cried and I cried. I think I cried so hard that I had to go to the hospital,…and it happened again; I started having panic attacks. I was exhausted, and yet I was still doing this [drugs & alcohol]. It took that to [pause] snap me out of the trance I was in, 'cause that's how it felt. It was like a "destroy yourself, because you failed." That's really what it seemed like, when I think back. I didn't want to live; I didn't want to live, either, so I lived a really high-risk lifestyle for the next couple of years after her death, and I didn't care. I really didn't care. I didn't care about anything. I was going to hurt myself as much as I could. That's when I just went, it was like I went crazy; that's how it felt. I went crazy with the lack of sleep and the constant stress.

Suicidal intentions "Alone and Lost"

A few of the women said that they got into exploitive relationships in an effort to get support. Patricia said "I had nowhere to go and no one to talk to". She said that the feeling of "weakness" and wanting to find support allowed others who were dysfunctional to start taking over her life. Several of the women mentioned that they

had thought about ending their own life and joining their loved one. Although most of them did not seriously contemplate suicide, for a few of them it seemed like the only way out. For many, the reason that they chose not to carry through with the suicide was not wanting to leave their children and wanting to save their children from what they had gone through by losing a loved one to suicide. Amy said that there were a number of times that she felt very alone and had seriously considered suicide.

> *I just felt so alone and lost. Then of course, my own biological family had issues, so I didn't feel like I had anyone to turn to, and so I thought that was a way out and then when at the last minute I decided not to. Yeah, there were, I guess, more than couple of times where the thought was there, and really, really, really thinking about it, and really considering it...I guess I came to that "Y" in the river of life, and I really seriously thought about suicide. I remember thinking, "I hate it. I hate the way my life is. I hate what I went through," and I wanted to end it. But then I thought about my kids, and I didn't want to leave them without a mom.*

Angie, with young children, also said that her kids had saved her. Following the suicide death she had gone through a very difficult adjustment period and had struggled with alcohol and addictions. She did not want her children to go through the grief and guilt that she had experienced:

> *But I think what saved me is my kids. My son - my son and my daughter, that's what saved me, 'cause I didn't want them to lose their mom like that. Even now, I don't want my kids to remember me like that, and be, like, "Holy shit, my mom killed herself! Maybe it's my fault" you know, I don't want them to think like that. I don't want my kids to remember me as a drunk or a coke-head or whatever, a pill head; I want them to remember me the way I am now. Like, I don't drink, I don't do drugs - like that. I want them to remember me that way, in a good way, so they have stories to tell their children and their grandchildren: "Yeah, my mom was crazy, but she was always there, always made sure we were fed and we ate, we had clean clothes" stuff like that.*

Martha said that suicide was not an option for her because she had a responsibility on this earth. Her children and grandchildren were counting on her to give them

strength. She felt that she needed to be around and the more "that sort of thing was thrown at her" the more motivated she was to become stronger. But, she stated that " it was quite a ride". For others, though, suicide was not an option for spiritual reasons. Mary, who was raised in boarding school, had been taught that suicide was wrong. Lucy thought that it was normal to think of taking your own life when you lose a child. However, she felt that if she did take her own life she probably wouldn't even see her son and she would still be in the dark. Mary, on the other hand, talked about why she would not take her own life:

> *I didn't want to do that. That part, I'm always strong about. 'Cause a long time ago, I had a friend that was talking to me, and I think it really sunk in, that part. He had told me that it's not right to commit suicide. If you ever think like that, you're not - your mind is not right when you think like that. And I think that stayed with me all my life, what he had said to me, and I never even THINK of that, like that.*

Turning Point to Healing

After a very difficult adjustment period the women in the study came to the realization that "life goes on". Martha described the healing journey as "one hard, difficult journey". For some of the women the healing journey began with a dramatic, sudden realization which one of them called a "turning point to healing" and another called "turning my life around". For others the transition to healing was more gradual and some of them said that they felt like they were just beginning their healing at the time of the interviews, 15 or 20 years after the suicide. They all expressed that they had this "hope! a spark!" which gave them the desire to get better.

One of the women said that "whatever happened happened, and you can't change it, you must go on with your life". Patricia said that she decided that she could not

continue to drown herself and make her life even worse, and added "plus I have a son". The participants expressed a strong desire to change and have a better life; they had to believe that life was going to get better. One of the women said "I knew I had to deal with that, I still had to deal with it. But I knew - that was when I believed that it was going to get better". Mary, who lost her son three years previously, said she didn't want to cry all her life. Martha said…

> *I needed to have that desire to want to get better. You have to find it within yourself that there's still that flame of hope. It was different people, different groups, or whatever, wherever I felt I needed to be, those were the things that helped me. But bottom line, I had that desire to be better. I WANTED to get better…one day, one morning; I'm lying there, thinking, "This pain is still here. What can I do with this pain; I want to get rid of this pain. Lord, help me." I find that's how I was, lying on the bed. So I forced myself, something sparked, and I said, "Get up! Get up! Go to that bathroom, take a shower, and face the day." And I did. That's what I did. That was the day I decided, "Okay, I've got to do something… But already, by that time, I had this hope, this desire, "I'm going to get well." I knew that.*

Several of the woman realized that they had to find a "different way to cope". Since some of them had only learned to cope by using drugs and alcohol, they needed to seek help to find another way. Amy said…

> *That's just what we did; like, that's just how we handle it. And I found it very [pause] I knew it wasn't right, and I knew I wanted to change, and I knew that I wanted a better life. So I decided to quit drinking*

The women had to believe in themselves and their own strength and realize that they were survivors and that they could "beat" this.

The Healing Path "Tough, Tough Work"

Many of the participants described the process of healing from grief as work because they really had to focus and work on themselves. Martha described it as "like

we do physical work; this was mental energy, just work, work, work - tough, tough work; mental work that was just as hard as physical work". Lucy also described healing as work. She said…

> *I would call it work, because you have to work on yourself and work on the people that are close to you… I just pushed myself, just kept going and going and going. But that was the only way that I thought I could do it, just to forget, just keeping myself working and working and working.*

Martha said that she had enrolled in whatever she could "stick herself in". She worked "academically, mentally, physically, and emotionally" in any program that she felt that she could be a part of. Lillian found that one of the key healing strategies for her was to reading books about suicide and dealing with grief. Sometimes she read them three or four times over. She said "I was so desperate for something that was going to help me, and I was so determined to keep going". Martha said that she enrolled in personal development courses and Cara took self-esteem courses and a grief recovery program. Betty organized grief workshops. She said, "How can I help these people and at the same time help myself"? Another woman described healing as "getting my strength back and rebuilding myself". Lucy said that she had to learn to accept that he (her son) was gone. Betty went on trips to try to find the answers. It had been eight years since the suicide and she was just beginning to accept the loss. A big part of the healing for her was learning to let her loved one go, even though he "took a big chunk of my heart". One of the things that helped was the realization that her loved one would have wanted her to be happy and to go on with her life. Martha described the work of healing:

Nobody's going to - nobody's going to slap something on me to fix me. This isn't going to go away on its own. I've got to work on it."…. So from that point on, it was a long, hard, difficult journey. The work was like the physical energy that I would do to say, it's challenging for me to wash walls; that's nothing compared to what I needed to do to get back into some kind of comfort. I was BROKEN, just broken. And the hard work there was trying to get back to some sense of normalcy; that was the hardest, hardest work! Like, trying to recapture that something you can't catch. But that was the hardest work.

Coping with the Loss

Spirituality "It's a Survival Technique"

All of the women talked about spirituality as an important part of their healing. It was what "pulled them through". Most felt that they would not have survived had it not been for their belief in a Higher Being, the Creator. Martha talked about how important spirituality was for her:

We're very spiritual people, eh, us Indians - Cree. I'm thankful for my parents instilling that in me, in us. To me, it's a survival technique. I don't know what I would do had I not - if that wasn't - if I wasn't a believer in that sort of thing. I honestly can't imagine how I would have handled it if I didn't have that, that connection to the Guy upstairs.

The spiritual help was essential for the women to have the strength to move forward. They found that going to elders was very helpful for guidance, support, and spiritual uplifting. The participants had faith that the elders would pray for them. Most of them also said that they spent a lot of time praying and smudging themselves. They participated in cultural ceremonies such as sweat lodges, feasts, and sun dance. Lillian, who had lost two sons to suicide, said that she had learned to forgive herself through cultural ceremonies. Patricia blamed herself for the death of her cousin and she said that she was at the point of psychological breakdown when she fasted and entered a sweat. After fasting and praying constantly Patricia recalled:

I felt stronger after that (sweat), because I gave a lot of it back to the Creator, and I asked for forgiveness. I believe in our ways, strongly...., that was what really changed me. Well, it didn't change me, it just found me. I couldn't even find myself. I wanted help so bad, and just asking, not a person, but asking the Creator was probably the most strongest thing that you can do when you seek.

Angie believed that entering the sweat helped her to cope with the pain of losing a boyfriend when she was 16:

We went to go sweat. After that, when I came out - like, when I went in, I was really hurt and stuff, and in there, I cried, and I kind of let go of whatever was bothering me, when I came out, it was just, like that elephant was off my chest. All that stress, everything, it was gone. Even all that pounding in the back of my head in here, it was all gone. Just being in that sweat, feeling that, knowing that those ancestors are there helping me to cope with this, that I'm not the only person or crazy person to go through this. ... I guess I'm not crazy after all, 'cause I know somebody else in this world is going through this now. I just hope that they can get through this or ask for help. Yeah. 'Cause before, I couldn't.

Martha talked about her faith and the help that she received when she went to see an elder:

Of course, having that belief. You have to believe that this spiritual person, that to me, is one of [the] Creator's helpers. You have to believe his role is to help you, is to make you well, to help you get better... it all goes back to beliefs, believing that there is Somebody up there that I can cling to and have faith, and say things are going to get better, and knowing where to go to get guidance, and that hope. Because that day, that day I went to see an elder, because I was just really - like, I was just really broken, broken down. And when he told me that - "I can't fix you," he said, "but I can give you something that will stabilize you," and I thought, "Yes, that's what I need.

Most of the participants had both Western and Traditional spiritual beliefs. Many had experienced both approaches to spirituality as children. Several of the women thought that it was all the same to them. Some of them mentioned going to church with friends. Patricia said "my faith and my trust is always in the Creator". Martha felt that it was the belief that there was "someone up there" that was the important thing. Amy found that the cultural traditions did not seem to work for her and she started to see

change when she found "the church and Christianity" and so she made the choice that Christianity was what she was going to believe in:

> *I believe there is another side. I believe there is a Creator and that he is bigger than us and he will help us overcome if we just believe.*

Prayer "It all goes Back to Praying, Believing"

The participants believed that prayer and having their belief to hold on to helped them in their lives and made them stronger. Some of the women said that initially they were so broken that they could not pray themselves, and felt that they could not have made it through without friends, family and elders praying for them until they were able to pray for themselves. For many, prayer, and smudging is what really helped them through the difficult times. Betty said that she wondered how she would ever get through the loss. She said that during the eight years following her loss she learned that you "pray like you never prayed before". She talked about her belief in prayer:

> *I tell them that the power of prayer, something that I really, really believe in, because I would phone my friends, my Christian friends, my church friends, and they would pray over the phone. They would pray for me. The elders, they would smudge me and pray for me. My daughter would come pick me up, say, "C'mon, Mom, let's go to a sweat." It's been a long, painful 8 years. I feel like that load is a little bit lighter now.*

Two of the women said that prayer was what kept them from resorting to chemical dependency. Martha said that prayer had helped her through difficult times:

> *I do have also a lot of faith in the Greater Power. I believe that there's someone greater than us that has control over us, has more power, has more love, has more - all the good things. I don't think I would have been able to survive had I not - if that faith wasn't there, because prayer, praying, and spirituality really pulled me through that difficult, difficult time that's what I needed!" Then also, having that faith in him (elder) to speak for me, to pray for me. Also telling me, "You can pray on your own, too." It all goes back to praying, believing. The whole concept of spirituality is so key in our survival - in MY survival, anyway. My life hasn't been pain-free; it hasn't been*

> *aching-free. When there is, I have to believe that things will get better with time, and believing that there's Someone up there that'll help, [pause] just to carry on; just to carry on I'm not saying ours is better. It's our belief; I respect the other groups' beliefs, but that's my belief. I rely on it, it's pulled me through so many difficult times.*

Connectedness "I Felt His Presence"

Most of the participants were comforted by being connected spiritually to the deceased, and knowing at certain times that their presence was with them. Martha expressed the belief that there are certain rare individuals that are up there that that can help, that can give hope to anyone that's willing. She also stated that she only shared this belief and her experiences with people whom she thought would understand and whom she could trust. Patricia spoke about not relocating to another town because her loved one's spirit was there and she felt connected to her. Keeping belongings was one way that mothers maintained a connection to their children. They spoke about keeping the deceased's possessions because they didn't want to give that connection up. Cara kept her daughter's hair; Mary kept her son's hockey bag and his three wheeler. Betty said that it was a comfort to her to have her deceased brother come to her twice while she was dancing at powwows.

Friends also had visits from the deceased. Two of the woman said that friends of their loved one had seen the departed dancing with them at powwows. They were comforted by the visits. Martha said that although initially she was angry at her husband for leaving her so suddenly, she felt great comfort that he was concerned about her and that he had visited a friend to tell her to take care of his wife. She also felt his presence when she moved back into their house and was comforted in knowing that he was there with her. Martha related her friend's experience:

She [friend] was sitting alone in her house all by herself. All of a sudden, a gust of wind blew, and somebody told her, "Go see [survivor]" She said, "You know what? It was him. That was his voice. He told me to go see you." Already, his spirit was helping me; already. I don't know if that makes sense, but it sure was a comfort when I heard that... after two months. So that first night was... I knew - I seen - I knew he was there; I felt his presence. So that was another comfort to me, and it almost, I think it gave me that ability, that capacity to clean up this house, because we always had it tidy, clean. So that's what gave me that motivation to clean up this house.

Lucy expressed comfort knowing that her son was in a good place after he came and talked to her to let her know that he was all right:

He's talked to me about a lot of things. He told me he was in a good place. He told me, "Not to worry, because I'm in a good place. It's not what you think that I'm in Hell," is what he told me. I guess that was always my biggest worry, was he's going to be in the dark forever for doing what he did. This is what he told me...I wasn't afraid for him any more.

She also recalled her years going to powwows with her son. Now that her son was gone she believed the powwows "keep her going" and she continued to dance because she felt that he was there with her.

...when I go to powwows, I go in the grand entry, but in my heart, in my mind, I'm praying that he'll be there with me. Sometimes just the two of us used to travel. I still dance. I feel like when I go out there, he's with me. It's been 16 years now he's been gone, but I still feel that way, that when I'm dancing, he's with me. I think that's one thing that kept me going was the powwows, too. I was thinking back, maybe that's why I'm still dancing; being that he was a dancer. He was a champion.

The participants talked about feeling especially close to the deceased during their memorial feasts, which were held once a year for four years. Mary said that she looked forward to the feast because she knew that her son would be there:

I looked - that first year looked so - like he was going to be there, that's how it made me feel. I did everything just to - I prepared everything what he liked, and I thought he would like. I was going to meet him there, that's how I felt, my first feast, first year. my food. It didn't make me feel - when we were there, I just thought, "He's

going to be there, I know it." That's how I felt. So I did everything the best, everything. The food, everything. I did everything I could to prepare for him.

Dreams "Don't Worry, I'm O.K."

Dreams were described by participants as a comfort and another way of receiving communication from the deceased. Often the dreams were a method to reassure the ones left behind that the departed was alright. The message was often "don't worry". Lucy said that following a dream, she was no longer afraid for her son:

I had this dream that really woke me up like, I wasn't afraid for him any more... a glow like a light, like gold, like really, really bright light, right into the universe, you can't - and then I noticed somebody walking upon this thing. And I looked. I was trying to recognize this guy. Then he turned around and he smiled, and he was really happy. He was my son; he was just leaving. And he turned around, and he kept walking. Then I woke up. So that really made me feel good. And to this day, I believe he's in a good place

Mary said that her son came to visit each of his friends once in "real powerful" dreams. In each dream at the end he told them "I have to go now". Martha dreamed that her husband came to hug her and she said that this had given her the strength to get better:

Yeah. Oh, yeah. Even, even my husband himself. I guess when you have a belief in God ... but that one night, after going through this series of sleepless nights and not eating, I dreamt, or so I thought, that he came. He came to me, he came to my room, and he came and hugged me. Then when I talked - I brought this to someone and they said he just came to make sure you are o.k. And when that happened, it also gave me the strength to get better, to get better, knowing that he still cares; that's how I thought of it.

Participants received advice and help from their loved ones or the grandfathers (ancestors) through dreams. The women frequently mentioned that the loved one was still watching over the ones left on earth. Kathy was told to quit drinking in a dream and this was a turning point for her. Her boyfriend had died before their child was born and

she frequently dreamt that the three of them were together. She described how her dreams made her feel:

> *Happy, 'cause I got to see him. I dream about him. The last time I dreamt about him was a couple of days ago. Yeah, two nights ago, I think. I was so happy in my dream, I started crying. I just hugged him. He just hugged me, crying to me, telling me that he missed me, that he's always comes to see the baby. Kind of blurry; I can' t remember parts of it. But that's cool. Whenever I have dreams about him, I know that he's watching over us, me and my daughter, especially my daughter. I just know he's around.*

The dreams also provided an opportunity for family to communicate back to the deceased. This was especially important because the death was so sudden that the family had no opportunity for "goodbyes". Mary spoke about waiting for her son to come to her in her dream:

> *I was waiting for him to come back in my dreams. He never did. That one day, one night, I dreamt about him again as a little boy. He came - he was standing with the crowd of people. They were just lining up, and he saw me, and I was just yelling, and he came running. And I just grabbed him. When I was holding him, he was grown up. I could just feel his hair; I was just rubbing his hair, and his back. I said, "I've been waiting for you to visit me," - he didn't even talk. He didn't say nothing. I said, "I missed you. I missed you so much," I said. "And I love you," I said to him. After we all gave up for a long time, he walked away, and he was standing on the line, in the line-up with the people. After that, I never dream about him.*

Support

The participants talked about the support they had received that had assisted them to heal. Support was essential to help the women go through the devastating experience of suicide and to realize that they had to move on in life. They identified family, friends, and professionals as being helpful. The women also described strategies such as; talking about it, keeping busy and having routine, comfort in nature, laughter, exercise, and avoiding drugs and alcohol as being critical to their journey of healing. Participants

relied heavily on the early teaching that they had received from their family and their cultural beliefs. Past experiences had also taught them to cope with loss.

Family "She Would be the One to Carry Me Through"

Family was usually named as the main source of support for the women. One family who had lost many of its members, found that it was very important to bond and try to make each other stronger. They said that they tried not to leave the burden with one person. Family support included physical, emotional and spiritual support. It meant just being there for whatever was needed including taking care of the survivor physically; making sure the family members ate, helping clean the house, or accompanying the survivor to spiritual activities. Often, the support included listening, talking, and praying for and with the participants. Family included immediate and extended family as well as adopted family. In one case it was an adopted sister who was "just there". She listened and allowed Martha to cry. Martha said her sister "would be the one to carry me through". "She allowed me to cry, she listened to me, she just was there, and I'm forever indebted to her". Often the family stayed together for extended periods either at the participants home or the extended family's home. The women said that when they were feeling lonely they would go to visit family for support. The participants said that they needed the family to be there for them and take time for them. Lucy recalled the support of her family after her son died:

> *It would have been just my family. They gave me a lot of support; like, they were there when I needed them, and even after that happened to my son, when he took his life, they stayed. Even after the funeral, they stayed. My sister stayed for a whole week, and then after she left, my brother was there. He stayed for about a month, just helping around with the horses and talking to me. He went out with my son [pause]*

he used to go hunting a lot. I think it was just to take things off his mind, because he was the one that found him

Sometimes the support was received by phone. Betty remembered talking on the phone for hours to her remaining siblings. She talked about her family's help:

Sometimes I would talk for a long time-even on the phone-with an elder or my brothers or my sisters, because after we lost [the third brother], it was so - because we hadn't dealt with the other two deaths... One of my brothers and my uncle were instrumental in really helping me cry, because they never gave up on me when I was really down, even to come here, even to come here in the morning, and come and pray, to come and smudge, or even to come in the evening and see me to come and do what was necessary for me

Children and grandchildren were a great source of support and understanding and they were an inspiration for the women to move on in life. They were often the reason the participant had to be strong and work toward recovery. Participants thought about how much they still had, the children and grandchildren that they had been blessed with and who still needed them. Martha said that her seven year old grandchild empathized with her and related the grandfather's death to how the child had felt when her dog died:

She said, "You know, kokum, are you feeling sad? That's how I felt, too, when we lost Bear" [their pet dog]. And you know what, that just made me feel so good. I did feel - a little 7-year-old! Can you imagine? So that was another factor that gave me a l-i-t-t-l-e more push.

A couple of participants, however, mentioned that their family was not there for them when they needed them. Sometimes the expectations that arose from being part of the family were difficult. This was especially true if the participant had always taken the lead role in the family and the family was used to relying on them for support. Betty said that her family was used to her being the "kin leader", but after she lost her second brother she fell apart and just couldn't do it anymore. Martha, who had lost her

husband, said that her sisters just didn't know how to support her. They could not deal with her not being the strong one.

Friends "I Just Talk to my Friends About It"

All of the women stressed the important role that friends had played in their healing journey. Kathy did not have much family support; however, her friends provided her with support. Her strongest support came from her two close friends:

> *My friends. My friends. I can't really say my family. My cousins, yeah. I never really talked about it with my mom. Just once in a blue moon, but not really. Just mostly my friend, the one who passed away, I always talked to her. She would always come see me. I'd even cry to her 'cause I was pregnant and everything was just getting to me I'd just go see my friend, and she'd just talk to me and whatever. We'd mostly laugh. She helped me a lot. Then I had help from my friends. They went with me to the wakes and the funeral and everything my friend, she just lost her baby's daddy, and she was - they were having their second baby when he passed away. And this was just recently, like maybe about 4 months ago. She was just telling me that - she said that it sucks, losing baby's daddy. Whenever I want to talk about him, I just talk to my friends about it.*

Some women said that they had friends who would come to see them and "do what was necessary…." Friends were there to listen to them and pray for them. Mary said that when she lost her son she didn't want to stay home anymore. She wanted to go back to work because she knew that her co-workers would support her and that she could talk to them. Martha really stressed the importance of having good friends to share with:

> *I think - I believe that it's important to have a connection with someone, even just one or two people. My God, you share whatever-you have this real closeness, your buddies. I have about five persons that I'm really close to. We tell each other stuff that we would take to our graves, that sort of thing. So I always say find someone that you trust. You never know when they might carry you, carry you through sometime.*

Two mothers who had lost sons also talked about the support that they had received from their son's friends. Mary and Lucy said that it made them feel good to

realize how much the friends cared for their son. Mary planned to adopt one of the friends in "the cultural way" as a "replacement" for her son:

> *Yeah, that's our plan, adopt one of his friends. But those four always come to the house. Whenever I see them, they come and greet me, or they'll come and hug me, asking me how am I doing. I always tell them, "You make me happy when you come and greet me or come and talk to me. It just makes me happy." I always tell them that. So I think they feel the same way. When they see us, they'll come up straight at us and just hug us, tell us. They feel like they're all my sons, those four boys. They're so dedicated, too. I guess they really cared for my son. They're always behind us, supporting us.*

Professionals "I Wasn't Ready For Them"

For some of the participants, professional help played a part in their healing. Other women did not access professional help at all. Lillian said that she had tried four therapists but that there was only one that she was comfortable talking with. Amy said that she had found the counselors very judgmental and so she didn't want to "access those resources". Martha described the importance of a trusting relationship with professionals:

> *Yeah, I went to - I saw a psychologist. In fact, I had to see a psychiatrist, but I can't say I got a heck of a lot out of the psychiatrist. He was merely there to sign my disability. But the psychologist helped me some, yeah; I believe that worked. But my thing was believing. [spiritual] And of course, I respect the psychology, psychiatry; I have enormous respect for them. I seemed to know who really cared, I seemed to sense - like, yourself, you're a very caring person; I sense that. It seemed like I had this extra sense that told me "Trust this person." And sure enough, I'd feel better after the contact. It seemed like there was this sixth sense.*

Cara said that she also went for counseling assistance:

> *I was able to get acquainted with probably three staff, at least three staff members... Like, I would make an appointment and I would go and see these people, talk to them about things that were going on mainly with my children.*

Patricia talked about her desperate search for help and her feeling that the counselors did not understand her situation:

> *I did go for help - I was there, I was going for my appointments and stuff, but it wasn't helping me. The only reason why I kept going, 'cause I wanted the help, and the lady had a nice, soothing voice. But there was nowhere to lay where I could just rest. 'Cause when I'd go from there, I'd come back here... it was a good thing, in a way; it gave me some support, but it wasn't enough. Because what I found was I felt I was being studied. I felt THAT I was being studied, and I felt that my community was being studied- it was not about me and what I was going through and how I was going to get the help. I needed help - and I felt nothing would help me. I was talking to people off and on, and no one - like, the doctors gave me pills for this and that, and nothing was working. I was just - I didn't know what to do. I just couldn't believe that it wasn't working. Those sessions, I was coming out of there with nothing. I'm not going to say don't trust the psychiatrists or a psychologist; I don't think they were ready for me, and I wasn't ready for them; it was a bad time for both of us... because I don't think the psychologist had the information to say, "Yeah, you will be experiencing this," or "You will be experiencing that." or say something like that.*

Mary recommended grief counseling for other people who had experienced suicide in their family but she had chosen not to go herself. She spoke about the reasons she did not go:

> *After I lost my son, I cried. 'Cause I didn't go for any counseling or anything, although what's-her-name was trying to ask me to come for counseling here. And I said, "Later. Later." I kept saying "later." I don't know. I think I was just holding on to my son ... I guess I'm still not that strong. It's going on 3 years. I still cry. I guess I should take grief recovery or something like that, but I don't know why, I just don't feel like coming here to talk about it. Maybe that's what I'm scared of, to break down when I talk about him. I was going to come here and see a counselor cause [she] kept asking me to come and see her, and I thought - then I thought, "I think I'm alright." I always thought, "I'm alright. I don't need her." But I guess I did need her, but I didn't come. I didn't talk to anybody at all.*

Talking About It "That Was My Way of Dealing with My Problems"

Talking about the loss was a very important part of the healing process for the participants. All of the women said that it really helped them to talk about the death and to talk about the deceased. They said that it made them feel good and they could go on

with life when they talked about it. Most of the woman talked with family, especially their own children, and friends. Kathy talked about the benefit of talking to a younger sister who "knows how to listen to everything", whereas other family members "talked, talked and talked". Her younger sister just listened to everything and didn't judge her. Although talking was important to the healing process, it was very difficult to talk immediately after the suicide. Some of the women said that they just cried when they tried to talk about it. Lucy talked about the process of learning how to talk about her loss. It was five years before she could talk about it. Talking about anything negative was especially difficult for Lucy because it made her feel guilty. At the time of the interview, 15 years after the suicide, Lucy was able to talk about the good and the bad times:

> *I think, to me, that was my way of dealing with my problems...talking about it. I talk about it all the time and I think that's what made me stronger...you just go on and be strong. And the more you talk about things, the more you'll be able to deal with them. Now today, I can talk about things about him [son] and laugh about it. Even the bad times we had together, like little arguments and stuff like that, I'm able to talk about it and not feel bad about it or guilty, I wasn't able to talk about it at all. And to this day, me and the kids, we talk about it, the good times and the bad times, and when he was little. This is where I am today... Today I can talk about it, and I can say, "My son committed suicide, and this is what I did."*

Two of the woman mentioned that they had someone to talk to who had gone through a similar loss. These friends were especially helpful because they really understood. Lillian found it very helpful when another parent who had lost a child spoke to her at her son's funeral:

> *... she lost about, I would say about three or four, some of her own kids, and some of the grandchildren, and she understands how she went through, and she's able to talk to people, with people who lost their kids, too. She was one of them that came and*

talked to me at the funeral. I still remember all that she said to me. She has a lot of knowledge and wisdom about that.

Other Strategies

The participants described other strategies that helped them to get through their ordeal and to move on with life, including keeping busy, connecting with nature and laughing. Some of the participants said that keeping busy and having a routine helped them to cope. Cara didn't want to give herself time to think or time to feel. She just wanted to keep busy and keep "her mental thing at capacity". Her schedule helped her to keep focused and to stay happy:

I always think there is no answer... just live day-by-day, I have my routine. I know I'm very honest with myself, and I don't - I have this schedule, I have this routine that really keeps me focused and really keeps me feeling happy. Like, I know I'm going to be happy. Even if I feel sad in-between.

Martha stated that her connection to nature helped her to feel safe and spiritually connected:

I soaked in the whole nature thing during our trip there. I did go out in a higher mountain to go say a prayer... A lot of nature connection, nature activity while I was there, just to give me that lift. And to feel that spirit, because I'm related to a bear. And I felt safe. I felt safe. It's just incredible how nature and that whole spirituality can be such a comfort and a blessing - and a healing for anyone.

Some of the participants talked about receiving comfort through laughter and how good it made them feel. Betty talked about her cultural belief in the gift of laughter and recalled the times when her family shared laughter:

Sometimes one of them will end up with something that brings laughter. And that's why, a long time ago, I guess different people would have different gifts, and when there was a death in the community, there was this one guy who had a gift of telling stories all night and making people laugh. They laughed through the night, 'cause they believed that laughter healed.

Cara found that walking was helpful to her. She recalled that for the first year following the suicide she went on two hour walks. Painting was another way that she used her spare time. She also sang in a church choir. Through singing she was able to keep thinking positively and to give something back to the community. Kathy said that drawing and writing helped her. She was able to put things in writing in her diary that she couldn't tell people:

> *I have two binders full of drawings, and that's helped a lot, too. 'Cause it would just be me and my daughter at home, and I would just draw while she's sleeping or something, or playing around. I could say a lot, but mostly I just write it down, my thoughts and whatever, and then I hide it. I have a diary. Yeah, and I drew a lot and I wrote a lot.*

Early Teachings "Special Gifts to Help You Understand"

All of the participants said that the teaching that they had received in their earlier years helped them to survive after the suicide. For most of the women the teaching came from their parents or grandparents. For Amy it was a friend's mother who was her role model. This friend provided her with the teaching she "hung onto". Later she also lost this role model to death. Several of the women said that when they were young they didn't really understand the teaching but when they went through the loss they understood what the lesson had been. Angie said that now she teaches her kids the things that her Mom used to say. The teachings included instruction in living healthy, avoiding alcohol, learning respect and parenting instruction. Many of the women spoke about the strong spiritual teaching that they had received while growing up. The spiritual teachings were traditional Aboriginal, Western, or a combination of both. Patricia said that because of the way that she was raised she had the traditional cultural

knowledge and experience. She said "I grabbed onto it and it brought me out of where I was". Martha described the teaching she received from her parents as a child. It helped her to face difficult situations:

> *Both my parents had a lot of wisdom. When I was young, there were times that I couldn't make any - I didn't really put that stuff together, but boy, did they make sense during this period.... I wouldn't have been able to pull through the whole thing had we not been taught to be - you know, to depend on the Higher Power, the Creator. Oh, most definitely. The whole concept of spirituality. We grew up in a praying house. When I was a child, we went to church every Sunday, and you know, that whole spirituality concept. Because we were all in it together as a family. I even thought - I even thought of my dad, my late dad, because I had a healthy relationship with my dad - like, he was my best friend... I was strongly connected to my dad. After he passed away, overcoming that, if I was faced with a difficult situation, I would think, "Okay, what would he say if I asked?" So yeah, the strength of my parents' spirits really ... But yeah, my parents' beliefs and their teachings sure helped a lot.*

For most of the women cultural beliefs were very comforting. Betty said "my people have very special gifts to help you understand". Lucy talked about the comfort she received from the teaching she learned from her grandparents that emphasized living one day at a time:

> *My grandparents, they taught me that like, you never worry about yesterday or tomorrow, just live for today, that's the way we are taught to live, one day at a time, just for today. My dad taught me today is what counts.*

Lucy felt very guilty about the suicide of her son. She recalled teaching from her grandmother that stressed that your time of death is appointed to you the day you are born. This belief helped to release her from guilt and from blaming others for her son's death. She was able to believe that it was meant to be and it could not have been prevented. Angie also recalled receiving comfort from her grandmother's teaching:

> *Yeah, 'cause she was the one that used to tell me that it was - that they're always in a better place from the world that we live in now. There's no more pain, there's no*

more suffering, there's just peace and quiet... And she said that: "Don't ever give up on your kids. They're given to you for a purpose," to look after them, to guide them, to protect them. And it was her way of showing us, to spend time with us and teaching us stuff.

Lillian recounted her parent's cultural teaching to learn from your mistakes. This helped her to forgive herself for the deaths of two sons:

Probably because that's a part of my roots, that's a part of my roots, and it's something that was a part of my dad and my mom and my grandfather that used to really support me through a lot of helping me deal with my past. A lot of that was through the cultural stuff - and my uncle - they were really into their culture. However, my dad - both my parents have always told me that as long as if I learn from my past mistakes, then the Creator forgives me. And as long as if I keep that in mind, then there's nothing for me to really worry about.

Although there was variation in cultural beliefs, a few of the women mentioned that some cultural teachings had caused conflict for them. Crying for the ones that had passed away was a concern for several of the women. Cultural teachings regarding suicide was also distressing for some of the participants. Cara mentioned that she wanted to get back into dancing because she enjoyed it but she felt that she was not supposed to:

I wanted to get back into dancing. Right after the loss of my daughter. I didn't - well, you're not supposed to. It's kind of like a cultural value. It's a ritual after you lose someone, you're not supposed to do things that you like, like dancing, so I had to quit, actually, for about a year after the losses, so I just ate.

A few of the women said that they believed in traditional teachings but they were not able to find an elder to provide them with cultural guidance:

I believe in our ways, strongly, but when I was here, there was nothing like that, really, here; we're just starting to get it back, slowly, here.

Learning through experience-"That's what makes us Strong"

The participants said that even though the experience that they had gone through was "almost worse than dying" and they would never forget the loss, they felt that they had learned from it. These "lessons in life" had made them stronger. After experiencing a suicide the women felt that they could cope with anything:

> *Even though I won't ever forget the event, it has strengthened me in terms of being able to- being able to withstand difficult situations and being able to - I just gained the extra strength that's needed ...But of course, I never forget ,I will never forget that time. It strengthened me emotionally, mentally, because surviving an ordeal like that, ...nothing else affected me*
>
> Martha

> *It's almost as bad as dying, having to live with all that hurt and that anger. It's really hard. It's heartbreaking, and it's really emotionally hard on a woman. But that's what makes us strong. But those hard times, they're like lessons in life; either you can go with them or go against them, but you've got to move forward, don't move back. You've always got to move forward. Whatever's happened, it's happened; you can't change what's happened. Just don't blame yourself. Things happen for a reason. God put us here for a reason. We're all gifts from God. Just like our children, they're gifts; they're not ours, they're His, so He can take any of us at any time, and we have no say in it. I can die tomorrow, but at least I know if I was to die knowing that I was sober and I was there for my kids, and I gave them stuff that I couldn't give them before when I was drinking*
>
> Angie

Past experiences had also taught the women to cope with loss. Some of the participants spoke of learning to cope with loss from an early age due to family deaths. One of the women said that "…every single loss affects us and we need to learn to deal with them". Mary thought that her experience in boarding school had helped her to learn to be strong because boarding school was a tough place to survive and she had felt that her parents didn't love her because they put her in boarding school.

> *It's probably when I was in the boarding school, I became stronger, I think, of my feelings. 'Cause I used to think I wasn't loved enough. But my parents must have loved me, but they didn't show it. There were other gangs there, too, that used to fight the girls. I was in a boarding school for 8 years, I think; 7 years, for sure.*

Hard Times "Bringing Back Memories"

For many of the women their loss was many years prior to the interview, however certain times or occasions still brought the pain back. One of the things that was very hard was another loss of a family member or friend that was close to them. Angie talked about how hard it was for her to lose somebody close to her:

> *But it was hard. I couldn't bring myself to go to a church or a graveyard for a real long time - for a REALLY long time. Almost 10 years, it took me. Even when I lost my granny last year, I just went to the church and the graveyard, and that was it; I couldn't do it anymore. It just brings back memories of stuff.*

Betty found that many things reminded her of her brothers. She discussed the pain and how she coped with it.

> *When I think of the day and when I see his children, I just cry. I just hold them. But it gets easier; every day, it gets a little bit easier. It's really hard.*

Special occasions like Christmas and birthdays were especially hard. Mary talked about the pain of Christmas without her son:

> *Being Christmas is near; I still remember shopping for him when I went to the mall. I thought - he was always the first one I would try and shop for, always the best clothes I could find for him. And he would always say that to me, "you're a good shopper Mom"". I told you we were always so proud of him...*

Lucy who also lost a son talked about how she dealt with the occasion of her son's birthday.

> *His birthday's coming up, and I'm having a hard time dealing with it. You know, one thing I do know about, and that's I give a party, a birthday party for him. It makes it a lot easier for me. I go get a cake, and we cook, and the things he used to like to eat, we put on the table, and the old man prays, and we all eat together. That's how I deal with that. It's hard - Christmas, any of the holidays, it's not too bad. His birthday is the hardest. Like, part of me aches. Not so bad here, but right here. I guess it'll always be there, that one... But we always have a feast for him,*

and then I make a plate, and I go put it at the head of his grave. And I sit there after the feast... after I put the food, and I talk to him.

Sharing Their Stories

The participants expressed a strong desire to give back to the community by telling their story and sharing what had helped them. Several of the women said that they already had people come to them to talk about their own losses because the community knew what they had been through. Lillian stated that she shared with people on her own because "the giving back" is a community thing. Lucy said that she wanted to help the community and benefit herself too. Martha talked about sharing her story of tragedy:

I felt that I needed to do this because I was born and raised in the community, and I've seen the way our community has devolved from when I was a child to now, and the importance of sharing information such as this, even though it's very personal... I've seen, I've heard, I've felt the pain and the cries for help. So I believe by sharing such a personal tragedy in my life - I feel that I came out of it. Despite the shock, getting over the despair, and the desire to want to come back to some kind of normalcy, it is possible. And I want to share that to other women, other whoever - males - because it was the most challenging difficult time of my entire life. THAT'S the reason why I agreed to be a participant in the current study. It didn't matter who the person is, it didn't matter where the study is coming from, I just need other community members to be aware and understand, and believe that they can come back to some kind of normal. I believe, because a lot of them were aware of this tragedy, there are times that they will come forward and talk to me about their situations.

The participants were asked to talk about what it was like for them to participate in the interviews, to tell their stories. All of the women said that although it was difficult for them to relive the story, participating seemed to have a cathartic effect. Kathy said that participating in the interviews "really, really helped" because she had never been able to talk about it before. Patricia said that she felt that it was easier to talk and hoped it would contribute to the healing process. Betty said that after the first interview she

was able to discuss some of the details of the suicide with her family that they had never been able to discuss previously. She had blamed herself for the death and had been carrying a heavy load. Following the interviews she was not afraid to feel the hurt and to share and give encouragement to her family. Lillian used the interviews as a sort of "yardstick" to measure how far she was along in her healing. She was pleased that she was farther along with her healing than she had thought. Amy found that it was a relief to talk about the suicide because the issues keep coming out and she can't go and start talking to just anybody about what has happened in her life. She felt like a weight was lifted and she felt lighter after being able to talk about it to someone that wanted to hear.

Most of the participants said that it was most helpful to talk to others who had gone through a similar experience, yet few of them reported having such a person to talk to. Several of the women indicated a desire to take part in a healing circle, support group, or participate in a victim's advocacy group for the families of suicide victims. Lillian said that if a mother who has lost a child or whose child has attempted talks to her she can relate to them. She felt that a group for sibling survivors of suicide was also very important because they could really relate to each other. She hoped that this would be a way of stopping the cycle of suicide. Cara said that she had not thought really deeply about it for some time and thinking about it again brought out a strong desire to try to prevent other families from being in the situation. Lillian believed that it would be very powerful to meet as a group because all of the women would be at different stages of healing and at least one person would be struggling. Still another participant said that

starting a healing group has been a dream of hers because the support was not there for her.

Lessons Learned

The criteria for resilience that was established by the advisory committee was women who had learned a lesson. The participants each talked about the lessons that they were given to learn through the difficult experience of surviving the suicide of a loved one. They felt that they wanted to share these lessons with other survivors of family suicide in order to save them from some of the pain that they had gone through. Their advice included messages of encouragement, advice to persist and messages of hope for other survivors:

Spiritual

> *Be thankful for what you have "I have to thank the Creator for the message that seemed to say, "Don't cry I'm alive".*
>
> *Just don't ever give up on yourself. Remember that God put us on this Earth for a reason; if He wanted to take us, He would take us. We're all gifts from God, we're His, and it's His call. So in a way, I think, morally, it's wrong to do that. But you've always got to remember to stay strong and believe in yourself, you can get through it.*
>
> *I think maybe that was one of the tests God put me through to see if I could handle it. I did. But I kind of think I handled it in a bad way, 'cause I think I should have asked I should have tried to ask for help, and I didn't. I kind of gave up; I kind of gave in to the drugs and the alcohol.*
>
> *Emotional*
>
> *I needed to have that desire to want to get better. You have to find it within yourself that there's still that flame of hope.*
>
> *It gets better, things aren't ever the same, but at least you can bring yourself back to a state of normalcy.*

Acceptance is crucial when you're going through that, accepting, and then the other stuff comes. Something is forever gone.

I just wait for the solutions to come around. But a lot of the solutions aren't just going to come, I have to have some input in there, I guess; there always has to be conflict in order for solutions to come around. So I understand that now, whereas before, I think I must have always thought that there were no solutions, that there was always only grief and negativity.

When people tell you they're going to kill themselves, you have to believe them.

I just want to try and be able to tell my kids "Don't ever resort to something like that. If something's really, really bothering you, you've got to talk to somebody."

Things happen for a reason, people make choices, I can't carry other people's burdens, and my life is mine to lead.

Things happen for a reason, people make choices, I can't carry other people's burdens, and my life is mine to lead.

I look at it as if somebody wants that help, they'll find it out there, and they'll be able to make the choice between the bottle and the help. Because I did. And to me, if I can do it, anybody can do it.

Just don't forget to ask for help. All the time, be there for somebody with an open heart and open ears. And whatever somebody says to you don't go around and brag about it. Especially really important things, keep them to yourself. That's what a person wants, I think for me, as a woman, I like to have somebody where I can confide in the most dark, hurtful things that I need to talk about and let go. And it's hard to find people like that nowadays, 'cause people are so busy with their own lives and their own problems. But it's good to sit down and talk to somebody that doesn't judge you or be judgmental, just have an open heart and open ears, open mind. And it will help, 'cause you know you can turn to that person and talk to them. 'Cause it does help.

I would encourage more people to talk about what happened to them.

Every day, I look at every day as being a learning experience; I'm going to learn something new every day. And that's how I look at life today.

God gave you a brain, ears, and eyes to see and listen, and before you take action, you have to think. That always is in my head.

Physical

I just had to learn to make healthier choices in my life... be around positive people, make healthy choices, and just believe.

I learned to take care of myself. I go visit, I go to the gym, or I work.

Mental

It is important to have at least one or two good friends because you never know when you might need them.

Life is short, life is precious. Take that time to take that extra minute to hug your child, to hug your boyfriend, to hug your relative, to hug your brothers and sisters. Always take that extra time. The work can wait.

I think that's my way of learning what unconditional love is. You give your love; you don't need anything back, you just give the love.

I make it a point, even when I'm talking to them [my children] on the phone, I make sure that I tell them that I love them. Because to me, I don't know when I'm going to die, and I don't want to get stuck - if I lose any of them, any of my girls, I don't want to be stuck with the "If only I had told them that I love them." I don't want to get stuck in that any more.

I've learned to spend a lot of time with my daughters.

When you go through something like that, you're glad that you love yourself; you respect yourself, because at a time like this, it helps.

I really think deeply a lot about who I am and what I've done, successes, and I just try to use my spare time, my talents.

I've learned that I'm only human, too, and I'm only one small part of this world.

I learned not to blame myself for stuff that I have no control over.

At least you bring yourself back to a state of "It's okay. I'm okay. Life really does have to go on." You get to that point, but boy, oh, boy, does it take a hard, hard, time

Discussion

Findings from this study provide a better understanding of how First Nations women cope and survive the loss of a loved one to suicide. In spite of experiencing a very difficult situation these women were able to keep going and to foresee a better future. Ten First Nations women had "learned a lesson" from their experience and therefore were considered resilient by community members. These women told the story of their initial reaction, the support that they found helpful, and the strategies which they used to cope following the death of their loved one. The women also talked about the pitfalls that they had encountered along the way including their struggles with drugs and alcohol. Most of the participants had been on their journey for many years and several felt that they had not yet completely healed. This was also found by another group of Aboriginal people in difficult circumstances who found that it had taken many years before they felt that they could "get on with their lives (Mill, Lambert, Larkin, Ward & Houston, 2005).

It was anticipated that it might be difficult to recruit participants to the study due to the sensitive nature of the research topic. Discussion of family suicide is very emotionally painful. The researcher felt a strong responsibility to the participants to present the findings carefully to safeguard the strength of the stories. She had also suffered the loss of friends and acquaintances due to suicide along with the community and felt grief and loss during the interviews. Following several of the interviews the participants mentioned feeling exhausted and the researcher also felt pain. During one

interview the researcher's field notes documented feeling chest pain along with the participant. The research supervisor provided support and debriefing to the researcher as required. It is possible that a prior relationship with the researcher may have influenced some participants and limited their willingness to disclose their experiences with suicide. It is recognized that the knowledge gained in this study may not be transferable to other Aboriginal communities because Aboriginal people are diverse in their customs and beliefs. Despite this limitation there are some beliefs and practices that are universal among First Nations people (France et al., 2004).

Resilience

In this study women were identified as the "backbone of the Aboriginal family". Aboriginal women have had an important and central role as sacred life givers and the health of their communities in many ways depends upon them (Chansonneuve, 2005; Walters & Simoni, 2002). In the current study participants demonstrated their commitment to their families and to their community. In spite of the agony that they had experienced the women were willing to share their stories in order to benefit others. Aboriginal women have been at the forefront of the healing movement (Aboriginal Healing Foundation, 2006). Although literature on resilience in Aboriginal people is limited, traditionally Aboriginal societies have placed great emphasis on fostering resilience and traditional resilience promotion strategies (Stout & Kipling, 2003). The women in this study had the ability to withstand adversity and have a good life outcome in spite of grief. Historically Aboriginal people have shown remarkable ability to survive and thrive despite incredible odds (White & Jodoin, 2003).

In an Indigenous culture, resilience is not only about individuals but also about the achievements of collectives such as families and communities (Durie, 2006). A common feature of wellness and strength for Aboriginals is an emphasis on the collective values of connection, interdependence, and community (Van Uchelen, Davidson, Quressette, Brasfield, & Demerais, 1997). In the current study the participants turned to their family and friends for support during their healing process. The support included practical help as well as emotional support. One of the participants identified a "chosen sister" who she said had "carried her through her ordeal." This ability to reach out has been identified as a characteristic of resilient women (Wright, 1998). Turning to family and community members for social support is characteristic of Aboriginal people and is usually the approach used in traditional healing (Ladd-Yelk, 2001; France, et al. 2004; Trimble & Hayes, 1984). One participant spoke of plans to adopt a son who was a close friend of their deceased son. Ladd-Yelk (2001) described the concept of adoptive kin who become like family in several minority cultures. In this study having close friends was found to be very important to assist in healing. Women in a northern Canadian community also identified having at least one close friend as contributing to their resilience (Leipert & Reutter, 2005).

Most of the women in this study had experienced a loss of loved ones at an early age. Some of the women identified this as a factor in helping them to be strong in surviving this loss. One woman also identified hardships in residential school as being a factor in her healing from the loss of her son to suicide. Previous experience with

hardship and personal loss has been reported as a catalyst for growth in other studies (Bachay & Cingel, 1999; Felten, 2000).

The participants identified a "turning point" which required a definite decision to work toward healing and to move on. One participant described it as finding that "flame of hope" within herself to get better. Family members in a study which focused on healing following youth suicide also made a clear and deliberate decision to move on to healing, life and living (Kalischuk, & Davis, 2001). Aboriginal women living with HIV also described reaching a "turning point" in adapting to their illness and shifting their life path in a more positive direction (Mill, 2000).

Participants used a range of strategies to help them heal. Talking about the loss to family and friends was found to be very helpful by the participants. Other strategies were more individual and they depended on what the individual enjoyed and found helpful. They included talking about the loss, keeping busy and having a routine, finding comfort in nature, laughing, powwow dancing, writing, painting and walking. Similar strategies were used by family members in a study of teenage suicide survivors (Kalischuk & Davis, 2001). Strategies included narrative and poetry writing, praying, drawing, music, reading, sculpting, visualization, enjoying nature, making a memory box, traditional healing practices, burning an eternity candle, and spending time alone. Self-care activities such as good nutrition, exercise and not drinking or using drugs were frequently mentioned as important factors in healing in the current study. Self-care and good health has been identified by women in other studies as being useful in helping to experience resilience (Felton, 2000; Humphrey, 2003).

Several women expressed comfort in an Aboriginal teaching that what was past was past. You could not change the past but you had to go on living and live for today. The women also were reassured by the belief that each child's destiny was set from birth and could not be changed. Ladd-Yelk (2001) also referred to a prophetic destiny for each child. These cultural beliefs helped to free the participants from the feeling of being responsible for the suicide. Focusing on today may reflect a cultural time orientation towards the present, incorporating the past, in contrast with the western tendency to focus on the future (France, et al, 2004).

These women expressed a strong belief in themselves and a desire to move on with their lives in spite of their loss. They were able to accept themselves and accept their loss as part of life. The ability to accept loss and come out stronger has been identified in other studies of resilient women (Felton, 2000; Humphreys, 2003; Valentine & Feinauer, 1993; Wagnild & Young, 1990). Some of the participants believed that their experience was a gift because they had learned lessons and reached greater spiritual awareness than they would otherwise have achieved. Lillian said that the tragedy of the suicide made her think that she wanted to change her lifestyle. A belief in being thankful for what you have been given is recognized as a cultural trait in Native American Indian cultures (Ladd-Yelk, 2001). The focus is placed on the positives in ones life rather than the negatives. Mill and colleagues (in review 2007) also found that many Aboriginal participants living with HIV viewed their illness as a gift that had triggered positive changes in their life. Survivors in other studies have also

described their difficult experiences as providing a key for unlocking the doors of self-discovery and self-growth (Kalischuk and Davis, 2001).

The participants in this study described lessons which they had learned through their experience. In Aboriginal cultures learning is viewed as a lifelong activity and individuals constantly strive to create balance and harmony (Aboriginal Healing Foundation, 2006). Learning a lesson was also described by the advisory committee as the essence of resilience. Barlett (2005) reported that Métis women also found that learning and reflecting was valued as a lifelong activity.

The participants stated that following the suicide they had learned the importance of expressing love to their family members. They also had a compelling desire to "give back" to the community and to assist others who had experienced the loss of a loved one to suicide. One of the key informants in this study described a participant's desire to participate in the study as an "urgency". Helping others became an important factor in their healing process. The desire to reach out to others in a more meaningful way following a suicide was also identified in a study with survivors of youth suicide (Kalischuk & Davis, 2001). Caring for others was identified as a factor that enhanced well-being in a study of older women (Felten, 2000). The participants in the current study were able to look beyond their circumstances and believe that the future would be better for them. This ability to reframe their situation has also been identified by women who survived sexual abuse (Valentine & Feinauer, 1993).

Aboriginal Beliefs

Spirituality was consistently described by the participants as being essential for their healing. Many of the women in this study stated that without their faith they could not have survived. A strong reliance on faith or spirituality was also found by Wright (1998) to be a key characteristic that promoted resilience. This is consistent with traditional Aboriginal views that mental health is much more spiritual and holistic than Western views and balance is an integral part of healing (Locust, 1988; White & Jodoin, 2003). The Native Medicine Wheel represents the cycle of creation, from birth to death in which balance between animals, nature, humanity and spirits co-exist (France, McCormick & del Carmen Rodriguez, 2004) Balance and harmony in relationships, including metaphysical forces is emphasized regardless of time, space, or physical existence (Cross, 1998; Ladd-Yelk, 2001) The Great Spirit, which the Indian turns to in times of need, is perceived to be everywhere (Dugan, 1985). The participants also shared the significance of spiritual ceremonies in their healing. Traditional interventions and therapies include healing and sharing circles, sweat lodges, fasting, and counseling by Elders (Aboriginal Healing Foundation, 2006; France, et al. 2004).

> *The sweat lodge symbolizes the womb. As the participants leave the womb they are symbolically reborn. The new beginning creates a new state of mind and a change in attitudes. Those who have cleared their minds during the ceremony can now see the power of the animal spirits and all of the hurt, anger and negative feelings are released (France, et al., 2004 p. 275).*

Several of the women said that they were able to forgive themselves and to release the anger that they felt towards, themselves, others and God through spiritual ceremonies. Patricia said that she was able to "find herself" again through fasting and the sweat lodge.

Several Canadian studies (Caine, 2002; Mill, 2000) have reported a strong desire by Aboriginal women to participate in ceremonies, as well as visits to elders and medicine men. The women found that spiritual ceremonies were a significant factor in maintaining and restoring their emotional, spiritual, mental, and physical well-being. Traditions and culture have been described by participants in several other studies as being a very important factor in helping them to be strong (Bachay & Cingel, 1999; Bobet, 2006 Felten, 2000). Many Native Americans consider their culture and religion one and the same (Ladd-Yelk, 2001). Leipert and Reutter (2005) also found that spiritual beliefs put Aboriginal women in northern British Columbia in touch with their culture and also with people who could support them. Some Aboriginal people, however, experience contradictions between the two forms of spirituality (Bobet, 2006). Although most of the woman in this study did not separate Western religion from Aboriginal forms of spirituality, one woman did feel that she had to choose between the two. A strong reliance on faith or spirituality was also found by Wright (1998) to be a key characteristic that promoted resilience.

The principle of connectedness was apparent in the comfort which the women received from continued communication with the deceased. Most of the woman spoke about their loved ones as being present and watching over them. This continuing bond of love between the survivor and the deceased was described by Kalischuk and Davis (2001) as a healthy expression of love which was represented as a "love knot". The women also spoke about receiving help from their ancestors, the grandfathers. The connections to others extend to those who have come before, the ancestors who are

sometimes referred to as "grandmother or grandfather" (Bobet, 2006). France and colleagues (2004) comment that "it is believed by First Nations people that those who have gone on before are watching over all from the spirit world". (p 276)

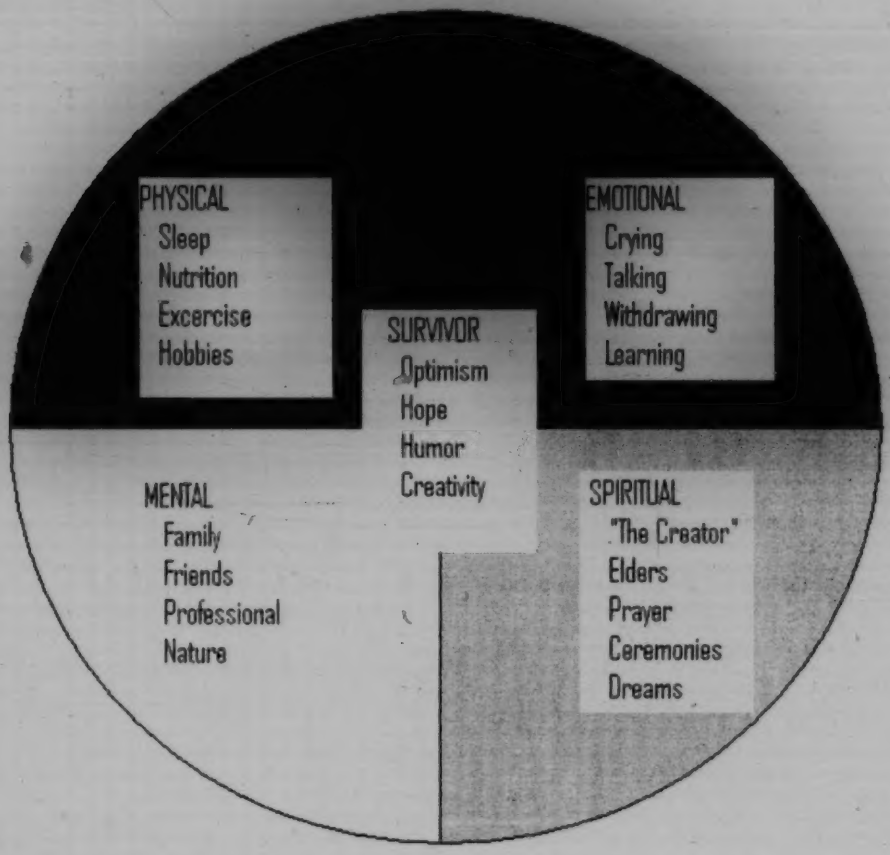
Dreams were also a vital link and a source of information and comfort to the grieving survivors. France and colleagues (2004) report that among some tribes of First Nations people, dream sharing is a vital part of their lives because it links them to the world beyond themselves. Dreams are pathways to other spiritual dimensions. Through dreams people find ways to deal with unexpected death and accept it without accusing the Above Beings for being unfair to them (France et al, 2004). Dreams prepare people to accept death as a natural consequence of living. Family members mentioned dreams as a powerful source of information in a study of suicide survivors (Kalischuk & Davis, 2001).

Martha also expressed receiving comfort from nature and from the bear, whom she believed to be her animal kin. This reflects a cultural belief in the kinship between humans and animals. For Aboriginal people a good relationship with animals helps to facilitate health and healing through the animal's spiritual power (Bobet, 2006).

Survivors on their healing journey struggled to restore balance to their lives corresponding to the traditional medicine wheel which stresses balance in all four areas of life: physical, mental, emotional and spiritual. A model (see figure 1) has been developed to illustrate the key components of resilience among survivors in the current study. The participants stressed the hard work that was required to regain balance. The survivor is represented at the centre of the circle. Characteristics of the women included

optimism, hope, humor and creativity. The women had to learn to be strong, to accept and believe in themselves. They stressed that they needed to find out how to forgive themselves and to accept that they were not responsible for others choices. They realized that life goes on and they had to learn to use their spare time, talents, and to celebrate their own accomplishments.

Figure 1: Resilience Following Suicide-Restoring Balance



Spiritual health

Spiritual help was vital to the participants for their survival. They had to believe that God was still alive and that their faith would get them through. They women learned to accept their loss and to be thankful for what they had. They went to elders for help, spent time in prayer, smudging, fasting, and attending ceremonies. Dreams also were helpful spiritually since they provided a link to communicate with their loved one.

Emotional health

Emotional healing often included initially withdrawing physically and emotionally. It also included extensive crying. Later healing included learning to talk about their loss and learning lessons needed to carry on with their life. The ladies stressed that they needed to have that desire to want to get better.

Physical health

Initially the women didn't care about themselves. As they healed they learned to take care of themselves and to make healthier choices. These included better nutrition, exercise and taking part in hobbies such as powwow dancing, walking, poetry and painting.

Mental health

Through their loss the women learned the importance of family and friends. They realized how much they had needed their support and they learned to make time with them a priority. The women learned to express their love for their family at every opportunity. Professional help was also used when there was a relationship of trust established.

Suicide

Participants described the loss as the most devastating experience they had ever gone through. Another study of suicide survivors also reported extensive emotional and personal suffering (Ness & Pfeffer, 1990). Participants in the current study reported that sometimes their families were overwhelmed and "just went their own way". This finding was also reported by Ness and Pfeffer (1990). In an effort to cope with their loss some of the participants turned to drugs, alcohol and other self-destructive behaviors. Silverman and colleagues (1994) reported similar findings including increased substance abuse and deliberate or indirect self-destructive behavior. Observing negative role models proved to be a motivating factor for some of the women. They saw other women who were dependent on drugs or alcohol and they did not want to follow that path. Todd & Worell (2000) also found that when people experience misfortune or threat to self-esteem they try to make themselves or their situation better by comparing themselves with someone less fortunate.

The women described an initial reaction of withdrawal from others and often from their surroundings. In a similar Canadian study (Kalischuk & Davis, 2001) the survivors of a suicide death also identified the need to retreat, to disassociate from their surroundings and to withdraw from others. This dormant period allowed the survivors time for introspection and it gave them a chance to try to make some sense out of their altered reality. The participants in the current study were consumed with the question of "why did my loved one choose to deliberately end his life?" This has also been found to be a critical question to other survivors of suicide. They often spent every waking moment searching for a definitive answer (Kalischuk & Davis 2001). The survivors

privately revisit this question over and over again. In an effort to find the answer the survivors replayed the still vivid details of the suicide in their mind. The participants in the current study said that although in some cases it was many years since the event they were able to recall every detail preceding the death. In the end, the survivors had to conclude that they would probably never know the answer to that question.

Bereavement from suicide has been found to be more difficult than other forms of death. Lillian found that the suicide deaths of her sons was much more difficult for her than the accidental deaths of her other sons, due to the intense guilt which she carried. She also said that people tended to stay away more from her following the suicide and this intensified her guilt. In a study of grief, Silverman (1994) found that survivors were more likely to assume responsibility for the loved one's death if it was due to suicide than other causes, believing they caused it or could have prevented it. Suicide survivors have more difficulty making sense out of the death (Silverman, Range, & Overholser; Range, & Calhoun).

Professional help was not used frequently and was not usually found to be very helpful. This reluctance may be due to a tendency for First Nation individuals to avoid mental health services because programs are designed to incorporate the dominant (biomedical) views of mental health and illness and ignore the Aboriginal cultural values (Morse, Young & Swartz, 1991; Trimble & Thurman, 2002; Smye & Brown, 2002). Spirituality is generally missing from Western approaches to mental health care (Aboriginal Healing Foundation, 2006). In addition, family members of youth suicide are sensitive to a rule of silence and secrecy that exists within the health care system

(Kalischuk, 2001). The reluctance to seek professional help may also be due to the fact that the participants are members of the community and confidentiality may be a concern for them.

The participants described the benefits they received from telling their stories. The telling of the stories provided a feeling of relief and a lightening of the load that they had been carrying. They were able to look back at the event and relieve themselves from some of the guilt. Talking through one's problems was traditionally recognized by Indigenous people as necessary and beneficial to healing (Aboriginal Healing Foundation, 2006). Aboriginal women living with HIV used stories to teach, to share, and sometimes to move on (Caine, 2002).The stories became therapeutic. Sharing and creating a common experience in storytelling aids in the development of people's ability to interpret events beyond their immediate experience. Stories can be used as ways to understand one's life through looking at symbols, creating analogies and bringing closure to diverse issues (France, et al)

Implications

A better understanding of the healing journey of First Nations women who have demonstrated resilience following the loss of a loved one to suicide will assist in providing support to other women who suffer a similar loss. Evidence from this study indicates that programs that are developed to work with Aboriginal suicide survivors should be designed with an Aboriginal perspective and a focus on wellness in keeping with Aboriginal health beliefs. Since spirituality played an enormous part in the healing journey of these women, both traditional and western spiritual support should be

included to provide clients the opportunity for choice. Although most of the women in this study utilized both belief systems, the support of elders and ceremonies was especially important to them. An elder should be available to the program participants because some people do not have access to an elder. Two women in the study did not know where to go because one was new to the community and the other had experienced family disruption. One of the women, however, did not follow traditional practices and she felt that she was "judged" because of it. Support groups and healing circles would be beneficial because most of the participants indicated that it was most helpful to talk to someone that had been through the same experience and yet few had that opportunity. Sibling support groups would also be beneficial because siblings have an increased risk of suicide. A mother who lost two sons believed that "siblings grieve differently". The participants stressed the importance of community suicide prevention programs to teach people to listen when a loved one threatens to commit suicide. Support is needed long term because the healing journey takes many years.

Parenting programs and cultural teaching for youth are necessary because of the cultural disruption that has occurred due to boarding schools. Findings suggest that it is important for nurses and others working with survivors of suicide to understand the dimensions of the healing process and to provide opportunities for the survivors to tell their story to an understanding, non-judgmental person who will "just listen". Individuals working with Aboriginal clients need to be familiar with the culture of the community that they are working in and the correct protocol. This can be accomplished by working in a team relationship with Aboriginal staff mentoring those not familiar

with the culture. People of Aboriginal heritage may also benefit from the teaching since not all Aboriginal people have had the opportunity to learn their culture. It is clear that establishing trust is an especially important factor in working with Aboriginal clients. It takes time to build a trusting relationship therefore every effort should be made to provide continuity of staff. The target population in this study was composed of Aboriginal women living on reserve. Further research is needed to determine if the findings are similar with other Aboriginal populations such as individuals living off reserve and non Aboriginal populations.

Conclusion

The stories of the ten First Nations women provide a better understanding and new insights about the healing path and factors that promote resilience following the suicide of a loved one. Although speaking about the tragic loss of their loved one was a very difficult experience, the women in this study shared freely with the researcher. The researcher had also known many of the people who died by suicide and she also experienced grief with the participants. The women were motivated to help the community by sharing what strategies had been helpful to them in their healing path and also to have the opportunity to tell their story completely to an interested person. The participants expressed interest in being part of a healing circle where they could share with other survivors of family suicide.

The researcher had worked many years in the community and she had identified the strength of the community women in spite of the adversities which they suffered. The women's dedication to their family was an inspiration to her. However, the

researcher had also experienced the loss of women who could not deal with the suicide of their family members and they chose to end their own life. These experiences provided a motivation for the current study in the hope that the information gained would help others who were struggling with suicide loss. The researcher was guided in the project by an elder and a community advisory group. Their support and guidance to the project was invaluable.

Participants described their initial response to the suicide as shock, disbelief, and anger. The consuming question was "why did my loved one take his own life?" The participants suffered feelings of guilt, blame and regret. Most of the women found that for a period following the suicide they withdrew either emotionally or physically. Following this, women felt guilt, blame and regret. After a very difficult adjustment period, the women reached a turning point and were able to accept their loss and move on with their life. Spiritual belief, support of family and friends and previous family teaching were the key supportive factors identified by the women in their healing journey. The women said that previous experience with loss also had helped them to learn how to cope with the loss of their loved one. The participants said that even though they would never forget their loved one they received lessons which they learned as a gift. They felt that by having learned to deal with this experience they would be able to cope with any difficult circumstances they might encounter in the future.

References

Aboriginal Healing Foundation. (2003).*Aboriginal People, Resilience and the Residential School Legacy.* Ottawa, Ontario: Anishinabe Printing.

Aboriginal Healing Foundation. (2005). *Reclaiming Connections: Understanding Residential School Trauma Among Aboriginal People.* Ottawa, Ontario: Anishinabe Printing.

Aboriginal Healing Foundation. (2003).*Aboriginal People, Resilience and the Residential School Legacy.* Ottawa, Ontario: Anishinabe Printing.

Aboriginal Healing Foundation. (2006). *Final report of the Aboriginal Healing Foundation. Vol III promising healing practices in Aboriginal communities.* Ottawa, Ontario: Anishinabe Printing.

Alberta Mental Health. (2006). *Aboriginal research protocols healthy Aboriginal people in healthy communities*. Edmonton, Alberta: Alberta Mental Health Board.

Adelson, N. (2005). The embodiment of inequity: Health disparities in Aboriginal Canada. *Canadian Journal of Public Health, 96, 45-62.*

Alberta Health and Wellness. (2004). *First Nations in Alberta a focus on health service use.* Edmonton, Alberta: Health and Wellness.

Bachay, J., & Cingel, P. (1999). Restructuring resilience: Emerging voices. *Affilia, 14,* 162-175.

Bartlett, J. (2005). Métis women in Manitoba.: Health and well-being for Métis women. *Canadian Journal of Public Health*, 96, (22).

Bobet, E. (2006). The mental health and well-being of Aboriginal Peoples in Canada.. In Government of Canada, *The Human Face of Mental Health and Mental Illness in Canada* (pp. 159-179). Ottawa: Minister of Public Works and Government Services Canada.

Brown, A. J., & Fiske, J. (2001). First Nations women's encounters with mainstream health care services. *Western Journal of Nursing Research, 23(2), 126-147.*

Brodkin, A., & Coleman, M. (1996). What makes a child resilient? *Instructor*, 105(8), 28-29.

Caine, V. (2002). *Storied moments: A visual narrative inquiry of Aboriginal women living with HIV.* Edmonton, Alberta: University of Alberta.

Canadian Institute of Health Research (2007).*Guidelines for health research involving Aboriginal People.* Ottawa, Ontario: Canadian Institute of Health Research.

Capital Health Authority. (2003). *How healthy are we? A technical report.* Edmonton, Alberta: Population Health & Research, CHA.

Cardinal, J.C., Schopflocher, D., Sevenson, L., Morrison, K., & Laing, L. (2004). *First Nations in Alberta: a focus on health service use*. Edmonton, Alberta: Health and Wellness.

Castellano, M. (2004). Ethics of Aboriginal research. *Journal of Aboriginal Health,* 98-114.

Chandler, M., & Lalonde, C. (2004). Transferring whose knowledge? Exchanging whose best practices? On knowing about Indigenous knowledge and Aboriginal suicide. In J. White, P. Maxim, & D. Beavon (Eds.). *Aboriginal Policy Research: Setting the Agenda for Change,* 11. (pp111-123). Toronto: Thompson Educational Publishing.

Chansonneuve, D. (2005). *Reclaiming connections: Understanding residential school trauma among Aboriginal people.* Ottawa, Ontario: Aboriginal Healing Foundation, Anishinabe Printing.

Clark, S., & Goldney, R. (1995). Grief reactions and recovery in a support group for people bereaved by suicide. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 16,* 27-33.

Corrado, R., Cohen, I. (2003). *Mental health profiles for a sample of British Columbia's Aboriginal survivors of the Canadian residential school system.* Ottawa, Ontario: Aboriginal healing foundation, Anishinabe Printing.

Cross, Tl (1998). Understanding family resiliency from a relational world view. In H.I. McCubbin, E.A. Thompson, A.I. Thompson, J. E. Fromer (Eds). *Resiliency in Native American and immigrant families.* (pp.143-157). Thousand Oaks, CA: Sage.

Dickson, G. (2000). Participatory action research: Theory and practice. In Stewart M (Ed.). *Community Nursing promoting Canadian Health (2nd ed.).* (pp542-563).Toronto: W.B. Saunders Company.

Diedrich, C., & Warelow, P. (2002). Suicide: a personal reflection. *Journal of Psychiatric and Mental Health Nursing, 9,* 169-173.

Durie, M. (2006, December). *Indigenous resilience: From disease and disadvantage to the realization of potential* Paper presentation at the Pacific Indigenous Doctors Congress, Massey University, Rotorua.

Edward, K., & Warelow, P. (2005). Resilience: When coping is emotionally intelligent. *Journal of the American Psychiatric Nurses Association, 11,* 101-102.

Everall, R., & Paulson, B. (2001). The teen suicide research project. *Alberta Journal of Educational Research, 47*(1), 91.

Felten, B. (2000). Resilience in a multicultural sample of community-dwelling women older than age 85. *Clinical Nursing Research, 9*(2), 102-123.

Fielden, J. M. (2003). Grief as a transformative experience: Weaving through different lifeworlds after a loved one has completed suicide. *International Journal of Mental Health Nursing, 12,* 74-85.

Fletcher, C. (2003). Community-based participatory research relationships with Aboriginal communities in Canada: An overview of context and process. *Pimatziwin: A journal of Aboriginal and Indigenous community health, 28-62.*

France, F., McCormick, R., & del Carmen Rodriguez, M. (2004). The red road: Spirituality and the Sacred Hoop. In France, M. H., Rodriguez, M., & Hett,

G. (Eds). *Diversity, culture and counseling: a Canadian Perspectiv,(pp.265-281).* Calgary, Alberta: Detselig Enterprises.

Gilbert, K. (2002). Taking a narrative approach to grief research: Finding meaning in stories. *Death Studies, 26,* 223-239.

Health Canada. (1996). *Trends in First Nations Mortality.* Ottawa: Minister of Public Works and Government Services Canada.

Humphreys, J. (2003). Resilience in sheltered battered women. *Issues in Mental Health Nursing, 24*, 137-152.

Kalischuk, R. G. (2001). A theory of healing in the aftermath of youth suicide, implications for holistic nursing practice. *Journal of Holistic Nursing, 19*, 163-186.

Kaufer, J., Commanda, L., Elias, B., Grey, R., KueYoung, T., & Masuzumi, B. (1999). Evolving participation of Aboriginal communities in health research ethics review: The impact of the Inuvik workshop. *International Journal of Circumpolar Health,* 134-144.

Kirmayer, L., Brass, G., & Tait, C. (2000). The mental health of Aboriginal peoples: Transformations of identity and community. *Canadian Journal of Psychiatry, 45*(7), 607-617.

Ladd-Yelk, C.J. (2001). *Resiliency factors of the North American Indigenous people.* Masters Thesis, University of Wisconsin, Menomonie, WI.

Lamet, A., & Dyer, J. (2004). Risk and resilience: Reactions of elderly Jewish holocaust survivors to current terrorist events. *The Journal of Multicultural Nursing & Health, 10*(1), 66-76.

Languedoc, Sue. (2006, June). *Aboriginal family violence: The journey around a broken circle. Telehealth* Presentation , Edmonton, Alberta.

Leipert, B., & Reutter, L. (2005). Developing resilience: How women maintain their health in Northern geographically isolated settings. *Qualitative Health Research, 15,* 49-65.

Locust, C. (1988). Wounding the spirit: Discrimination and traditional American Indian belief systems. *Harvard Educational Review*. 58, 315-330.

Loiselle,C., & Profetto-McGrath, J. (2004).*Canadian essentials of nursing research*. Philadelphia : Lippincott.

Macaulay, A., Delormier, T., McComber, A., Cross, E., Potvin, L., Paradis, et al. (1998). Participatory research with Native community of Kahnawake creates innovative code of research ethics. *Canadian Journal of Public Health, 89*(2),105-108.

Macaulay, A., Commanda, L., Freeman, W., Gibson, N., McCabe, L., Robbins, et al. (1999). Participatory research maximizes community and lay involvement. *British Medical Journal, 319*, 774-778.

McLeod, A. (1997). *Aboriginal Communities and HIV/AIDS*. Final Report. A joint project with the Canadian AIDS Society and the Canadian Aboriginal AIDS Network. Ottawa, ONT: Canadian AIDS Society.

McTaggart, R. (1991). Principles for participatory action research. *Adult Education Quarterly, 41*(3), 168-187.

Meleis, A. I. (1996). Culturally competent scholarship: Substance and rigor. *Advanced Nursing Science, 19*(2), 1-16.

Mill, J. (2000). Describing an explanatory model of HIV illness among Aboriginal women. *Holistic Nursing Practice* 15(1), 42-56.

Mill, J., & Ogilvie, L. (2003). Methodological issues in Nursing research establishing methodological rigour in international qualitative nursing research: A case study from Ghana. *Journal of Advanced Nursing, 41*(1), 80-87.

Mill, J., Lambert, D., Larkin, K., Ward, K., & Houston, S. (2005) *Challenging Lifestyles: Aboriginal Men and Women Living with HIV.* Final report, June 20, 2005.

Mignone, J., & O'Neil, J. (2005). Social Capital as a health determinant in First Nations. *Journal of Aboriginal Health*, March, 26-33.

Ministerial Council on HIV/AIDS Special Working Group on Aboriginal Issues. (2001). *Situational Analysis: A Background Paper on HIV/AIDS & Aboriginal People*. Ottawa, ONT: Author. Available at www.healthcanada.ca/aids.

Morse, J. & Field, P. (1995). *Qualitative Research Methods for Health Professionals* (2nd ed.). Thousand Oaks, California: Sage Publications.

Morse, J., & Richards, L. (2002). *Readme first.* Thousand Oaks, California: Sage Publications.

Morse, J., Young, D. & Swartz, L. (1991). Cree Indian healing practices and Western Health care: A comparative analysis, *Social. Science. Medicine.* 32, 1361-1366.

National Aboriginal Health Organization. (2002). *Improving population health, health promotion, disease prevention and health protection services and programs for Aboriginal people*. Ottawa: Kinnon Consulting.

Ness, D., & Pfeffer, C. (1990). Sequelae of bereavement. *Journal of Psychiatry, 147,* 279-285.

Newbold, K. (1998). Problems in search of solutions: Health and Canadian Aboriginals. *Journal of Community Health, 23*(1), 59-73.

Patterson, M., Jackson, R., & Edwards, N. (2006) Ethics in Aboriginal research: Comments on paradigms, process and two worlds. *Canadian Journal of Aboriginal Community-Based HIV AIDS Research,* 1(Summer), 47-57.

Polit, D., & Beck, C. (2004). *Nursing Research Principles and Methods*, Philadelphia, Lippincott.

Range, L., & Calhoun, L. (1990). Responses following suicide and other types of death: The perspective of the bereaved. *Omega, 21*(4), 311-320.

Royal Commission on Aboriginal Peoples. (1993). Appendix B: *Ethical guidelines for research.* Ottawa: RCAP Minister of Supply and Services Canada.

Royal Commission on Aboriginal Peoples (1996). *People to people; nation to nation: Report of the Royal Commission on Aboriginal Peoples, Vol3: Gathering strength.* Ottawa: Minister of Supply and Services Canada.

Rubel, B., (2005). *Suicide survivor grief.* Retrieved January 24, 2005 from http://griefworkcenter.com.html.

Rudestam, L. (1992). Research contributions to understanding the suicide survivor. *Crises, 13*(1), 41-46.

Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science, 8*(3), 27-37.

Silverman, E., Range., & Overholser, J. (1994). Bereavement from suicide as compared to other forms of bereavement. *Omega, 30*, 1994-1995.

Smith Tuhiwai L. (2005). On tricky ground: Researching the Native in the age of uncertainty. In Denzin, N. & Lincoln (Eds.).*The Sage Handbook of Qualitative Research*, (pp.85-107). California: Sage Publications.

Smy, V., & Brown, A. (2002). Cultural safety and the analysis of health policy affecting Aboriginal people. *Nurse Researcher*, 9, 42-56.

Smylie, J., Kaplan-Myrth, N., Tait, C., Martin, C., Chartrand, L., Hogg., W. (2003). Health sciences research and Aboriginal communities: Pathway or pitfall? *JOGC*, 211-216.

Statistics Canada, (2001). Department of Indian Affairs and Northern Development. *Census Highlights on Registered Indians*, Ottawa: Statistics Canada, 1995.

Stout, M., Kipling, G., & Stout, R., (2001). *Aboriginal women's health research synthesis project*. Ottawa: Centres of Excellence for Women's Health Research Synthesis Group

Todd , J. & Worell, J. (2000). Resilience in low-income, employed, African American women. *Psychology of Women Quarterly, 24*, 119-128.

Trimble, J. E. & Hayes, S. (1984). Mental health intervention in the psychosocial contexts of American Indian communities. In W. O'Conner & B. Lubin (Eds.), *Ecological Approaches to Clinical and Community Psychology*, 293-321.

Trimble J. E., & Thurman. P.J. (2002). Ethnocultural considerations and strategies for providing counseling services to native American Indians (p53-91). In P. Pedersen, J. Draguns, W. Lonner & J. Trimble, *Counselling Across Cultures*, (5th ed). Thousand Oaks, CA:Sage.

Tusaie, K., & Dyer, J. (2004). Resilience: A historical review of the construct. *Holistic Nursing Practice, 18,* 3-8.

Valentine, L., & Feinauer, L. (1993). Resilience factors associated with female survivors of childhood sexual abuse. *The American Journal of Family Therapy*, 22, 216-223.

Van Uchelen, C., Davidson, S., Quressette, S., Brasfield, C., & Demerais, L. (1997).What makes us strong: Urban Aboriginal Perspectives on wellness and strength. *Canadian Journal of Community Mental Health,* 16, 37-45.

Wagnild, G., & Young, H. (1990). Resilience Among Older Women. *Journal of Nursing Scholarship, 22, 252-255.*

Wagnild, G., & Young, H. (1993). Development and psychometric evaluation of the Resilience Scale. *Journal of Nursing Measurement, 1*(2),165-178.

Waldrum, J. (2004). *Revenge of the Windigo: The construction of the mind and mental health of North American Aboriginal Peoples*. Toronto: University of Toronto Press.

Walters, K., & Simoni, J. (2002). Reconceptualizing Native Women's health: An Indigenist stress-coping model. Americain Journal of Public Health, 92. 520-529.

White, J., & Jodoin, N., (2004*). Aboriginal youth: A manual of promising suicide prevention strategies.* Calgary. Alberta: Centre for Suicide Prevention, Canadian Mental Health Association.

Williams, D., & Lawler, K. (2001). Stress and illness in low-income women: The roles of hardiness, John Henryism, and race. *Women & Health*, 32(4), 61-75.

Wright, M. (1998). Resilience. In E. Blechman & K. Brownell (Eds.). *Behavioral medicine and women: A comprehensive handbook* (pp.156-161). London: Guilford.

Wyrostok, N., Paulson, B. (2000). Traditional healing practices among First Nations students. *Canadian Journal of Counselling*, 34(1), 14-23.

Young, T, (2003). Review of research on Aboriginal populations in Canada: Relevance to their health needs. *BMJ, 327*, 419-422.

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Appendix B: Research Information Letter

Title of Research Study: Resilience in Aboriginal Women

Principle Researcher: Lyla Goin, Masters of Nursing Student, Faculty of Nursing, University of Alberta, Edmonton, Canada

Supervisor: Dr Judy Mill, Faculty of Nursing, University of Alberta

Background: I am doing this study as a student in the Master of Nursing Program at the University of Alberta. I will work with a group of community women who are my advisors. An elder will oversee the project. The purpose of the study is to help understand what assists women to be strong (resilient) following the loss of a family member to suicide. We hope that by talking to women who have learned to cope with their grief we will learn how to help other women to cope. You are being asked to participate in this study because you have experience in this area.

What will happen: If you agree to participate in the study, you will be asked to take part in an interview. The interview will be with me and it will be done privately at a time and place that is convenient for you. The interview will take about 1 1/2 to 2 hours. You will be asked to tell the story of your healing after losing a loved one to suicide. I would also like to hear your suggestions on ways to assist other women who are dealing with the loss of a loved one to suicide. With your consent I will record our conversation. You may request that the recorder be shut off at any time. You will be given a small gift for the interview to help compensate you for your time. You will be asked to meet a second time to make sure that the information was correctly understood and to give you the opportunity to add more information if you wish. You will also be given a small gift for that interview.

Confidentiality: Any information that is collected from you will remain private. I will be the only one who knows that you took part in the study. I will not reveal the names of any people interviewed in any verbal or written account of the research. Your name or any other identifying information will not be attached to the information you give. Your name will never be used in any public release of the study results. The information that you provide will be kept for at least seven (7) years. It will be stored in a secure filing cabinet.

Possible Benefits: The benefits that you may receive as a result of taking part in this study include being able to express your feelings regarding the loss of your loved one. By being in the study you will also have an opportunity to contribute to our understanding of how to help other Aboriginal women in the community who suffer the loss of a loved one to suicide.

Possible risks: It is not expected that there will be any risk to you if you take part in this study. You may find it difficult to remember and to talk about your loss. If you feel distressed as a result of our discussions and would like to talk to a counselor you will be seen by a mental health counselor in Hobbema.

Voluntary Participation: Taking part is entirely your choice. You are not required to take part in this study. If you decide to be in the study and then change your mind, you may withdraw at any time. You may also request that the voice recorder be shut off at any time.

Contact information: If you have questions at any time about this study please contact me. You may also contact my supervisor, Dr. Judy Mill at the Faculty of Nursing, University of Alberta. We will be happy to answer any questions you may have. Our contact information is included below. In the event you have concerns and would prefer to contact a representative of the Faculty of Nursing who has no direct involvement with this study, please feel free to contact:

Dr. Kathy Kovacs-Burns, Director of Research, Faculty of Nursing, University of Alberta, Edmonton, Alberta. Phone: 780 492 3769 or e-mail: kathy.kovacsburns@ualberta.ca

Sincerely,

Lyla Goin

Lyla Goin , RN, MN student Faculty of Nursing University of Alberta Phone 780-387-4192 Email: lgoin@ualberta.ca	Dr. Judy Mill Faculty of Nursing University of Alberta Phone: 780 492 4338 Email: judy.mill@ualberta.ca

Appendix C: Consent to Participate

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Appendix C: Informed consent for participants
Project: **Resilience in Aboriginal Women**

Part 1: Researcher Information		
Name of Principal Investigator: Lyla Goin Affiliation: Masters in Nursing Student, University of Alberta Contact Information: Lyla Goin 780-387-4192		
Name of Supervisor: : Dr. Judy Mill Affiliation: Faculty of Nursing, University of Alberta Contact Information: 780-492-7556		
Part 2: Consent of Subject		
	Yes	**No**
Do you understand that you have been asked to be in a research study?		
Have you read and received a copy of the attached information sheet?		
Do you understand the benefits and risks involved in taking part in this research study?		
Have you had an opportunity to ask questions and discuss the study?		
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and it will not affect your care.		
Has the issue of confidentiality been explained to you? Do you understand who will have access to your records/information?		
Part 3: Signatures		
This study was explained to me by: _____ Date: _____		
I agree to take part in this study. Signature of Research Participant: _____ Printed Name: _____		
Witness (if available): _____ Printed Name: _____		
I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate. Researcher: _____ Printed Name: _____		
* A copy of this consent form will be given to each participant.		

Appendix D: Guiding Questions Initial Interview

1. Can you tell me about (loved one)?
2. Please tell me the story of the loss of your loved one (to suicide).
3. Describe how you have been able to cope since from the loss of (loved one).
4. Who/What has been helpful to you in your healing?
5. What advice would you give to someone else who has lost a loved one to suicide?
6. What else would you like to tell me that we have not talked about?